

FOR STATE
HEALTH DEPT.

If any delay is necessary, please
execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12660

Reg. Dist. No.

| | | | |
|---|---------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montg | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton | | c. LENGTH OF STAY IN lb 3 months | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11712 Viers Mill Rd. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Wheaton, S.S. | |
| 3. NAME OF DECEASED (Type or print) Clay Todd Ackerman | | f. STREET ADDRESS 11712 Viers Mill Rd. | |
| 4. DATE OF DEATH Nov. 19, 1959 | Month Nov. | Day 19 | Year 19 |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 8/16/59 |
| | | | 9. AGE (In years from birth) yrs. 5 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 13. FATHER'S NAME Robt. E. Ackerman | | 14. MOTHER'S MAIDEN NAME Ora Lee Culver | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Robt. E. Ackerman | | Address Item 2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia | | | |
| DUE TO Upper Respiratory Infection | | | |
| in bed | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| DUE TO (b) Upper Respiratory Infection | | | |
| DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | DATE SIGNED 11/19/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 11/21/59 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM PARKLAWN CEMETERY | | 22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WERNER E. PUMPHREY INC. <i>Raymond L. Ziska</i> | | ADDRESS SILVER SPRING, MD. | |
| | | 24a. REC'D BY REGISTRAR DATE NOV 24 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | |

STATE OF
THE PECULIAR

EXAMINER'S CERTIFICATE OF SEALS

14

15

16

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12701

CERTIFICATE OF DEATH

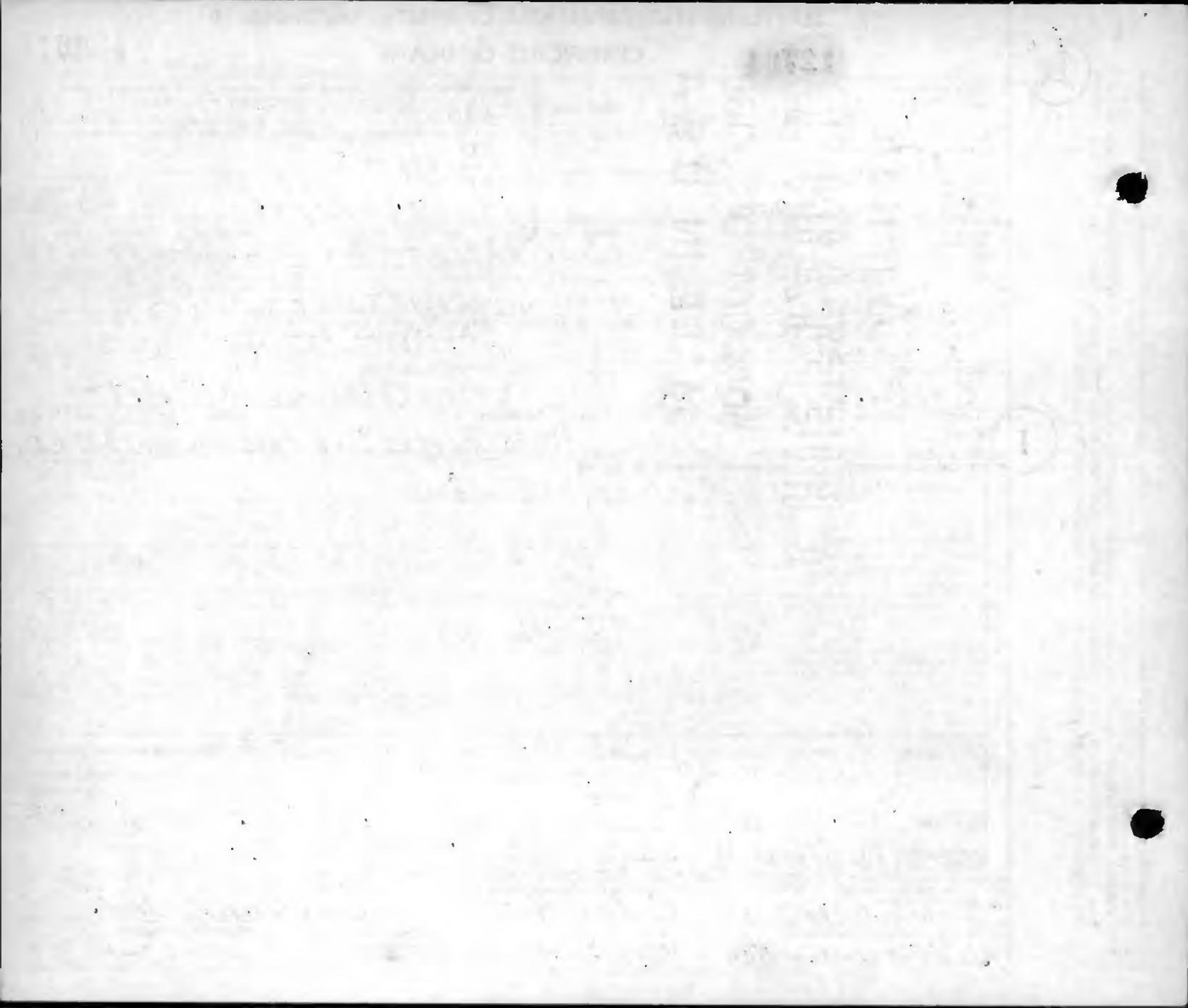
Reg. Dist. No.

12661

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery County</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rewington Gardens</i> | | b. COUNTY <i>Baltimore County</i> | |
| c. LENGTH OF STAY IN 1b <i>Residential 70</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rewington Gardens</i> | | d. STREET ADDRESS <i>14-D Rehov Ave.</i> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 03x-2 | |
| 3. NAME OF DECEASED (Type or print) <i>SUSAN Catherine D'Aleert</i> | | 4. DATE OF DEATH Month Day Year <i>November 29 1959</i> | |
| 5. SEX <i>Female</i> | | 6. COLOR OR RACE <i>White</i> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>July 20 1872</i> | |
| 10a. US-NATIONAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>None</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Annapolis, Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | |
| 13. FATHER'S NAME <i>Col. George W. King</i> | | 14. MOTHER'S MAIDEN NAME <i>Susan Catherine D'Aleert</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>None</i> | |
| 17. INFORMANT <i>Mrs Bertha D. K. Freyman, Wash. D. C.</i> | | Address <i>5320-4th St. N.W.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>36 hours</i> | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>None</i> | | | |
| (c) DUE TO <i>None</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Generalized Arteriosclerosis</i> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>None</i> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>None</i> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>None 19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>None</i> | |
| 21. I certify that I attended the deceased from <i>July 30, 1959</i> to <i>November 29, 1959</i> that I last saw the deceased alive on <i>November 29, 1959</i> , and that death occurred at <i>5:30 P.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>James M. Loftus</i> | | ADDRESS (Street, city or town, state) <i>1673 Park Road, N.W., Nov. 29, 1959</i> | |
| PHYSICIAN'S NAME (Type) <i>James M. Loftus</i> | | DATE SIGNED <i>Nov. 29, 1959</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i> | | 22b. DATE THEREOF <i>12-3-59</i> | |
| 22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill</i> | | 22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Deaf Funeral Home</i> | | ADDRESS <i>4812 Gaithers Rd.</i> | |
| 24a. REC'D BY REGISTRAR DATE <i>DEC 8 '59</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **12662**

| | | | | | |
|---|--|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE Md | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookmont | | c. LENGTH OF STAY IN 1b 25 yrs. | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookmont | | d. STREET ADDRESS 6335 Ridge Dr | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6335 Ridge Dr | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Frederick William Arnold | | First | Middle | | |
| | | Last | 4. DATE OF DEATH Nov 8 | | |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 8. DATE OF BIRTH 12-27-88 | | 9. AGE (in years last birthday) 70 yrs. | 10. IF UNDER 1YEAR Months 0 Days 0 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gov. Printing Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Kansas | 11. BIRTHPLACE (State or foreign country) U.S.A. | | |
| 13. FATHER'S NAME Gustave Arnold | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Ely. Arnold (wife) Stev 2 | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH sudden | | | |
| PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary occlusion | | DUE TO 408.1 | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) | | DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) hypertension 5 yrs | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour e. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE Frank J. Bloschert | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 11-8-59 | |
| EXAMINER'S NAME (Type) FRANK J. BLOSCHELT | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 11/10/59 | | 22c. NAME OF CEMETERY OR CREMATORIALy Cedar Hill Crematory | |
| 22d. LOCATION (City, town, or county) Suitland, Maryland | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Maryland | | 24a. REC'D BY REGISTRAR NOV 13 '59 | 24b. REGISTRAR'S SIGNATURE Clinton & Trahan |
| VS. A15ME(S) SM 9/55 | | | | | |

HT-2000 1C-3 級於 1989 年兩輪車輛之最速紀錄。

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12663

12703

CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL or **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | |
|---|----------------------------------|---|-------------------------------------|--|---|--|--------------------------------------|----------------------------|------------------|
| 1. PLACE OF DEATH o. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia | | b. COUNTY ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 58 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington | | d. STREET ADDRESS 2810 Elmwood Drive | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md. | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Gay | | First Ellen | Middle ATEHY | Last ATEHY | 4. DATE OF DEATH November 9 1959 | Month November | Day 9 | Year 1959 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-29-47 | | 9. AGE (In years last birthday) 11 yrs. | IF UNDER 1 YEAR Months 11 | IF UNDER 24 HRS. Days 0 | Hours 0 | Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) District of Columbia | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 13. FATHER'S NAME Edward ATHEY | | | | 14. MOTHER'S MAIDEN NAME Eileen SHANDOLPZER | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | INFORMANT (Father) Edward Athey | | Address Same as #2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 227X | | | | | | | | | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiorespiratory failure (c) massing tumor involvement | | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 3 wks | | | | | | | | | |
| DUE TO (b) chest abdomen (c) Mesothelioma | | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 1 yr. | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Hemorrhage into intestine | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) U.S. Naval Hospital, Bethesda Md. | | (County) 11-9-59 | (State) |
| 21. I certify that I attended the deceased from 12 September 1959 to 9 November 1959 , that I last saw the deceased alive on 9 November 1959 , and that death occurred at 3:05 A.M. from the causes and on the date stated above. | | | | | | | | | |
| ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. | | | | | | | | | |
| DATE SIGNED 11-9-59 | | | | | | | | | |
| ACTUAL SIGNATURE <i>G.B. Avery</i> | | M.D. U.S. Naval Hospital, Bethesda Md. 11-9-59 | | | | | | | |
| PHYSICIAN'S NAME (Type) G.B. Avery LT MC USN | | U.S. Naval Hospital, Bethesda Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11-12-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Arlington National | | 22d. LOCATION (City, town, or county) Arlington Va. | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Murray</i> | | ADDRESS Demaine 520 South Washington St. Alexandria Va. | | 24a. REC'D BY REGISTRAR NOV 16 '59 | | 24b. REGISTRAR'S SIGNATURE <i>C. L. Thomas</i> | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12664

12704

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE | c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CHEVY CHASE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5525 GREYSTONE ST. | d. STREET ADDRESS 15525 GREYSTONE ST. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) BERTHA | First | Middle | Last |
| 4. DATE OF DEATH NOVEMBER 27 1959 | Month | Day | Year |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JANUARY 17, 1880 |
| 9. AGE (In years lost birthday) 79 yrs. | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS. Days | 12. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) GERMANY | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME LOESER ADLER | | 14. MOTHER'S MAIDEN NAME MATILDA -- | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT JOSEPH B. DRATCH | | Address 5525 GREYSTONE ST. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancerous Mastectomy</i> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <i>Cancer of Breast</i> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 4/26/57 to 11/27/59 | |
| Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 9-26, 1957, to 11/27, 1959, that I last saw the deceased alive on 10-25, 1959, and that death occurred at 3:45 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>David H. Kushner</i> ADDRESS (Street, city or town, state) DATE SIGNED PHYSICIAN'S NAME (Type) DAVID H. KUSHNER M.D. 1302-1821 2.41 | | | |
| 22a. BURIAL, CREMATION, REMOVAL SPECIALTY BURIAL | | 22b. DATE THEREOF NOV. 29, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM KING DAVID MEMORIAL GARDENS | | 22d. LOCATION (City, town, or county) FALLS CHURCH (State) Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY & SONS | | 24a. REC'D BY REGISTRAR ADDRESS 3501-14 ST. NW DATE DEC 1 '59 | |
| 24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG252 11-25-9 et

CERTIFICATE OF DEATH

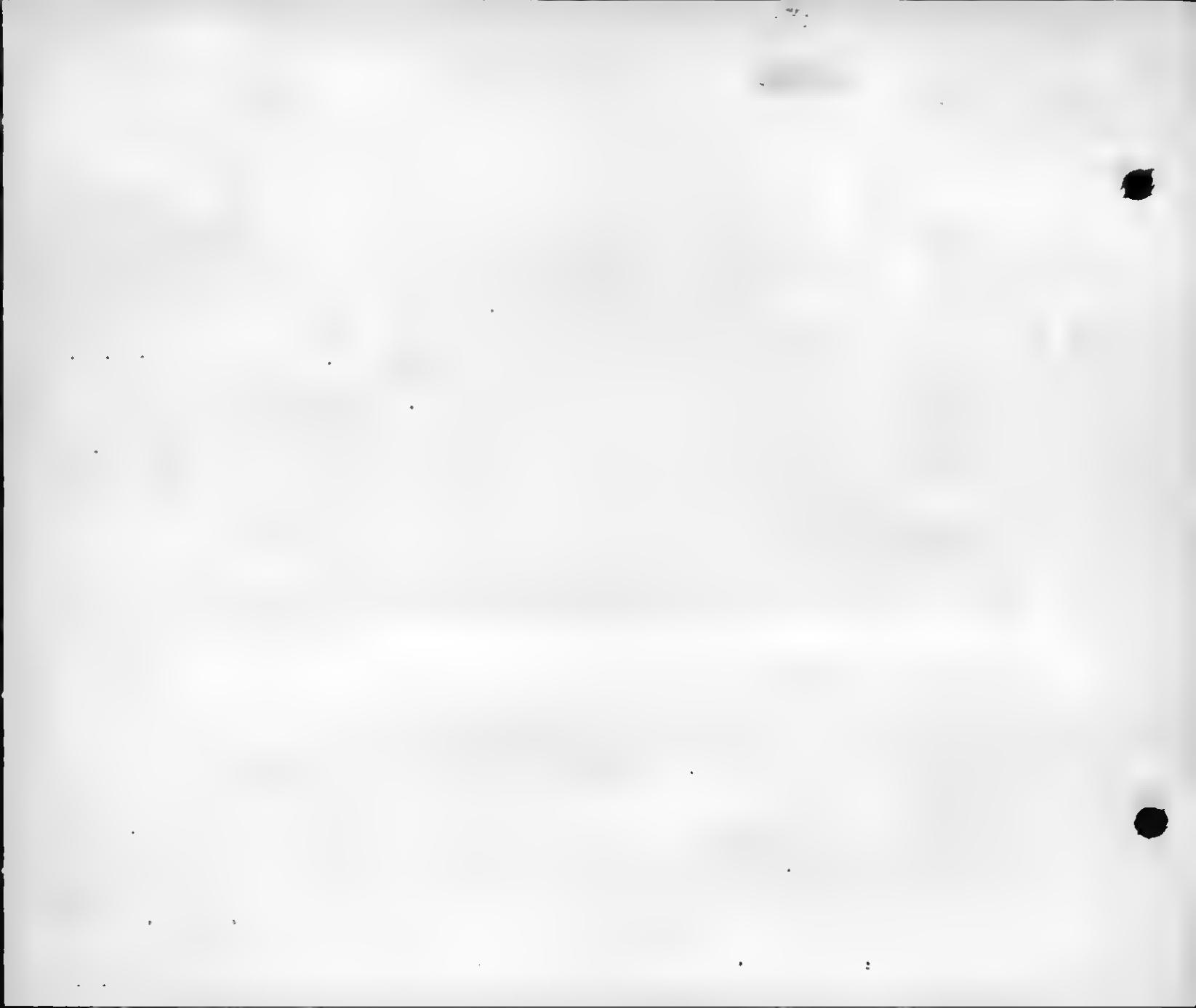
12665

Reg. Dist. No.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg | | c. LENGTH OF STAY IN 1b 4 yrs 1 mo. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home for the Aged, Inc. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Baer | | d. STREET ADDRESS 3609 Buena Vista Avenue | |
| | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX Female white | | 6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Sept. 6, 1879 | |
| WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. AGE (In years last birthday) 80 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Frederick, Md. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME George W. Young | | 14. MOTHER'S MAIDEN NAME Mary E. Albaugh | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 17. INFORMANT none Asbury Methodist Home, Gaithersburg, Md. | |
| Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 8-21-57 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>56</u> , to <u>Nov 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 11</u> , 19 <u>57</u> , and that death occurred at <u>9:25A M</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Sarah E. Glover</u> PHYSICIAN'S NAME (Type) <u>Sarah E. Glover</u> | | ADDRESS (Street, city or town, state) <u>M.D. 10128 Cedar Lane, Kensington, Md.</u> DATE SIGNED | |
| 22a. BURIAL, CREMATION OR REMOVAL (Specify) <u>burial</u> | | 22b. DATE THEREOF 11-28-56 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL <u>Olivet</u> | | 22d. LOCATION (City, town, or county) <u>Frederick</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner</u> | | ADDRESS <u>Gaithersburg, Md.</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>NOV 20 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>L. K. Lewis</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12666

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12786

Reg. Dist. No.

TO DEPUTY
 This certificate shall be executed within 14 days after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be
 written the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| <u>Montgomery</u> <u>MARYLAND</u> | | a. STATE <u>Md</u> | b. COUNTY <u>Baltimore</u> |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | |
| <u>Bethesda</u> | | 4 yrs | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| <u>9825 Singleton St</u> | | d. STREET ADDRESS <u>9825 Singleton St</u> | |
| 3. NAME OF DECEASED (Type or print) | | First <u>Regina</u> | Middle <u>Maria</u> |
| 3. NAME OF DECEASED (Type or print) | | Last <u>Baer</u> | 4. DATE OF DEATH Month Day Year <u>Nov 18 1959</u> |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>1-11-1874</u> 9. AGE (In years last birthday) 85 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | 10c. BIRTHPLACE (State or foreign country) <u>Hungary</u> |
| 13. FATHER'S NAME <u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT <u>Jan Clifford - Item #2-great grand child</u> |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | <u>Coronary occlusion</u> <u>400.1</u> DUE TO | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. | | (b) <u>Hypertension</u> <u>1/2 hr</u> DUE TO (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | DATE SIGNED <u>11-18-59</u> | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>11-23-59</u> | 22c. NAME OF CEMETERY OR CREMATORIUM <u>Gate of Heaven Cem.</u> | 22d. LOCATION (City, town, or county) <u>Silver Spring, Maryland</u> (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u> | | ADDRESS | 24a. REC'D BY REGISTRAR DATE <u>NOV 23 '59</u> |
| | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraas</u> |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

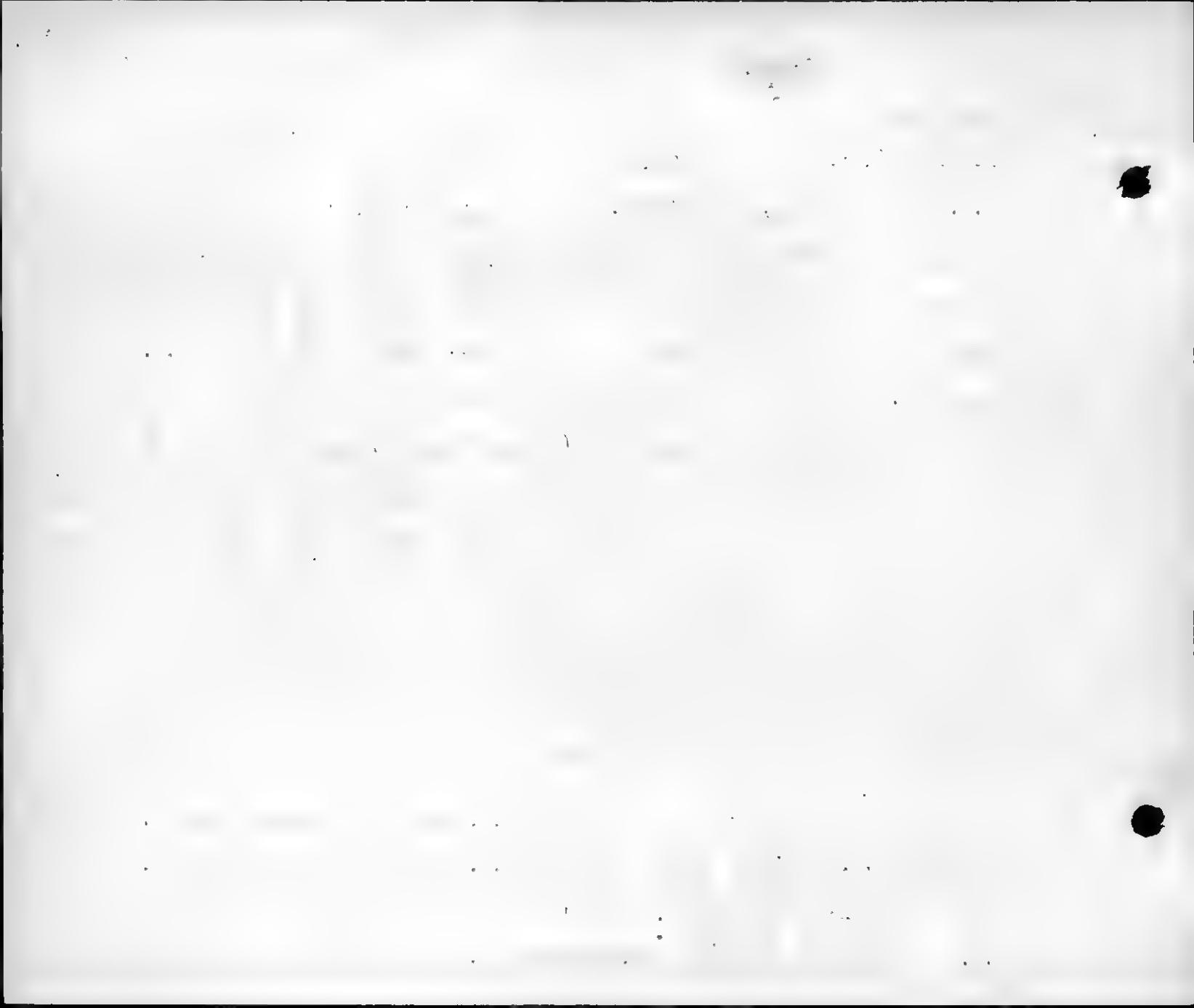
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12667

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | | | | |
|--|---------------------------------|---|--|---|--|---|--|------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived) f institution Residence before admission a. STATE Maryland | | b. COUNTY X | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c LENGTH OF STAY IN lb 33 days | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park | | d STREET ADDRESS 46 Selamaua Court | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md. | | | | | | e. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) Theresa Dianne Barber | | First | Middle | Last | 4. DATE OF DEATH November 6 1959 | Month | Day | Year |
| S. SEX Female | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH 6-8-56 | 9 AGE (In years last birthday) 3 yrs | F UNDER 1 YEAR Months 3 | IF UNDER 24 HRS Days Hours Min. | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b KIND OF BUSINESS OR INDUSTRY None | | 11 BIRTHPLACE (State or foreign country) New Jersey | | 12 CITIZEN OF WHAT COUNTRY? U.S. | | |
| 13. FATHER'S NAME Darwin L. Barber | | | 14. MOTHER'S MAIDEN NAME Betty A MC KEE | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No | | 16. SOCIAL SECURITY NO. None | | INFORMANT (Father) Darwin E Barber | | Address Same as #2 | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-respiratory failure INTERVAL BETWEEN ONSET AND DEATH immediate | | | | | | | | |
| 18x DUE TO Massive tumor involvement of chest and abdomen 2 wks. | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Wilms tumor DUE TO Wilms tumor 1 year | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | | | | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | | | | |
| 20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from 4 October 1959 to 6 November 1959 that I last saw the deceased alive on 6 November 1959 , and that death occurred at 6:15 A.M. from the causes and on the date stated above. | | | | | | | | |
| ACTUAL SIGNATURE G.B. Avery LT MC USN ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 11-6-59 | | | | | | | | |
| PHYSICIAN'S NAME (Type) G.B. Avery LT MC USN U.S. Naval Hospital, Bethesda Md. | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11-10-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM St. Joseph's Cemetery | | 22d. LOCATION (City, town, or county) (State) Beatrice Nebraska | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey ADDRESS 7557 Wisconsin Ave. Bethesda Md. 24a. REC'D BY REGISTRAR DATE NOV 10 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | | | | | | |



X
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12668

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 1 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY 12708 Montgomery | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b DOA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital | | e. STREET ADDRESS 4813 Wellington | |
| f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Elsie | First E. | Middle X. | Last Bargagni |
| 4. DATE OF DEATH 11 16 1959 | Month 11 | Day 16 | Year 1959 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 9, 1887 |
| 9. AGE (in years last birthday) 72 yrs. | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS. Days | 12. IF UNDER 24 HRS. Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (State or foreign country) Washington, D. C. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME William Macaboy | 14. MOTHER'S MAIDEN NAME Macaboy | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | |
| 16. SOCIAL SECURITY NO. ----- | 17. INFORMANT No | Address Mary Bargagni 4813 Wellington Dr. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion INTERVAL BETWEEN ONSET AND DEATH sudden | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ | | | |
| DUE TO (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) History of previous heart disease 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE FRANK J. Bioschait | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 11-16-59 |
| EXAMINER'S NAME (Type) FRANK J. Bioschait | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 11-19-59 | 22c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery | 22d. LOCATION (City, town, or county) (State) Rockville, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland | ADDRESS | 24a. REC'D BY REGISTRAR NOV 18 '59 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12709

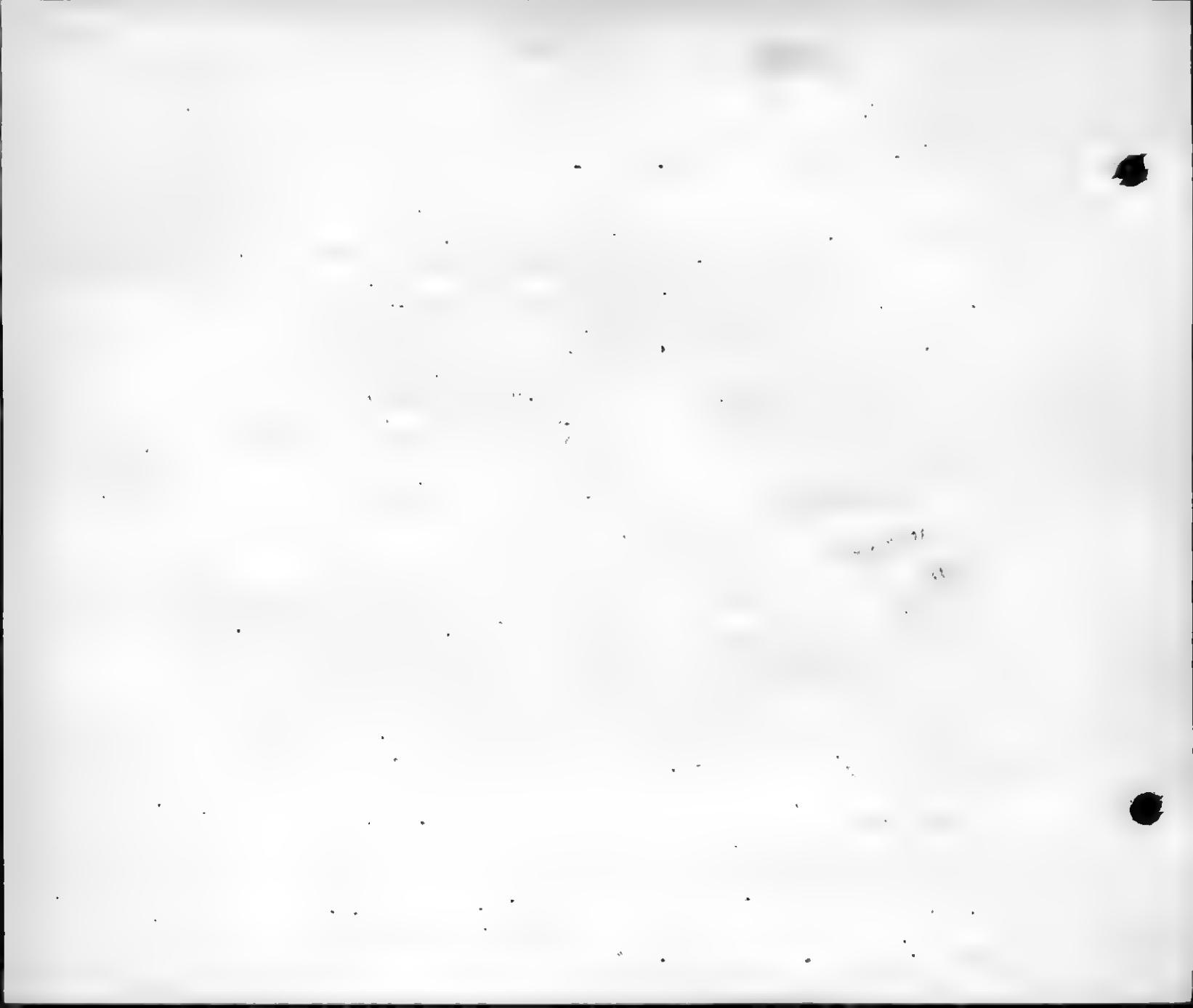
CERTIFICATE OF DEATH

Reg. Dist. No.

12669

TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE | |
| <i>Montgomery</i> | | <i>MARYLAND</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b RURAL and give nearest town) | |
| <i>Bethesda</i> | | <i>2 days</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| <i>Suburban</i> | | | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle |
| <i>Theresa C. Barrett</i> | | | |
| 4. DATE OF DEATH | | Month | Day |
| | | 11 | 11 |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| <i>Female</i> | | <i>W.</i> | <i>March 22, 1881</i> |
| 8. DATE OF BIRTH | | 9. AGE (In years last birthday) yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min. |
| | | <i>78</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| <i>Homemaker</i> | | <i>RETIRED U.S. Govt.</i> | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <i>W. Virginia</i> | | <i>U. S. A.</i> | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| <i>Patrick Welsh</i> | | <i>Mary A. Dunn</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. INFORMANT Address | |
| <i>No</i> | | <i>DR. Barrett Son</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | <i>Congestive failure</i> | |
| 4/22/1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | <i>191 5 days</i> | |
| (b) DUE TO | | | |
| (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| <i>Diabetes - Diabetic gangrene legs</i> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| | | | |
| 21. I certify that I attended the deceased from <i>July</i> , 1957 to <i>May 11</i> , 1959, that I last saw the deceased alive on <i>May 11, 1959</i> , and that death occurred at <i>10511 SUMMIT AVE., PENSINGTON, MD.</i> ADDRESS (Street, city or town, state) | | DATE SIGNED | |
| ACTUAL SIGNATURE <i>Horace W. Bernton</i> | | | |
| PHYSICIAN'S NAME (Type) <i>HORACE W. BERNTON</i> | | 21. LOCATION (City, town, or county) <i>WASHINGTON, D.C.</i> (State) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 22b. DATE THEREOF <i>11-14-59</i> | |
| 22c. NAME OF CEMETERY OR CREMATORIAL <i>MT OLIVET CEMETERY</i> | | 22d. LOCATION (City, town, or county) <i>WASHINGTON, D.C.</i> (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Francis J. Collins 3821-14th St., N.W. Wash. D.C.</i> | | 24a. REC'D. BY REGISTRAR <i>NOV 13 59</i> | |
| ADDRESS <i>Francis J. Collins 3821-14th St., N.W. Wash. D.C.</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur & Kline</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

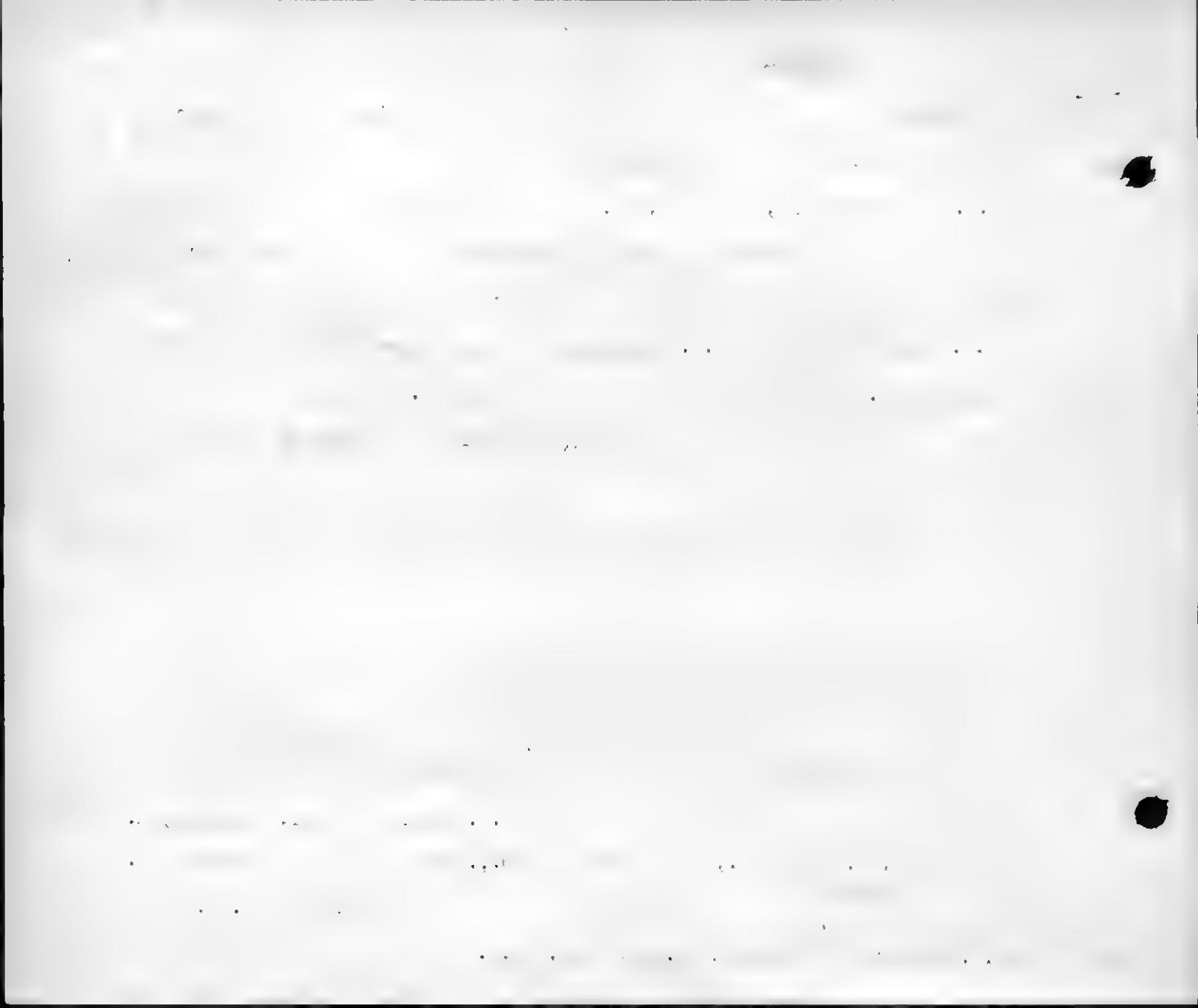
12670

12710

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|-----------------------------------|--|--|--|------------------------------------|
| 1. PLACE OF DEATH o. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Res dence before admission) o. STATE North Carolina | | b. COUNTY Spencer | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN lb 3 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Spencer | | d. STREET ADDRESS 515 5th Street | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md. | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | First Jackson | Middle Lee | Last BARRINGER | 4. DATE OF DEATH | Month November | Day 28 | Year 1959 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH 9-7-34 | 9. AGE (In years last birthday) 25 yrs | IF UNDER 1 YEAR Months 25 | IF UNDER 24 HRS Hours 0 | IF UNDER 24 MRS Min 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Government | | 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZENSHIP OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Benjamin A. BARRINGER | | | | 14. MOTHER'S MAIDEN NAME Lorena S. ARENDT | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes 1958 to 1959 | | 16. SOCIAL SECURITY NO 241-42-9744 | | INFORMANT (wife) Mary Ann BARRINGER | | Address Same as #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1930 DUE TO B12.1: Cancer (G.100, 1st stage) INTERVAL BETWEEN ONSET AND DEATH 1 year | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) B12.1: Cancer (G.100, 1st stage) (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 25 November 1959 to 28 November 1959 that I last saw the deceased alive on 28 November 1959 , and that death occurred at 1150A M , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 11-29-59 | | | | | | | |
| ACTUAL SIGNATURE A. T. THORP Jr. | | | | | | | |
| PHYSICIAN'S NAME (Type) A. T. THORP Jr., LT MC USN | | U.S. Naval Hospital, Bethesda, Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 12/3/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM National | | 22d. LOCATION (City, town, or county) (State) Salisbury, N. C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers | | ADDRESS 1400 Chapin St. NW, Wash., D.C. | | 24a. REC'D BY REGISTRAR DEC 2 '59 | | 24b. REGISTRAR'S SIGNATURE Orville S. Knapp | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12671

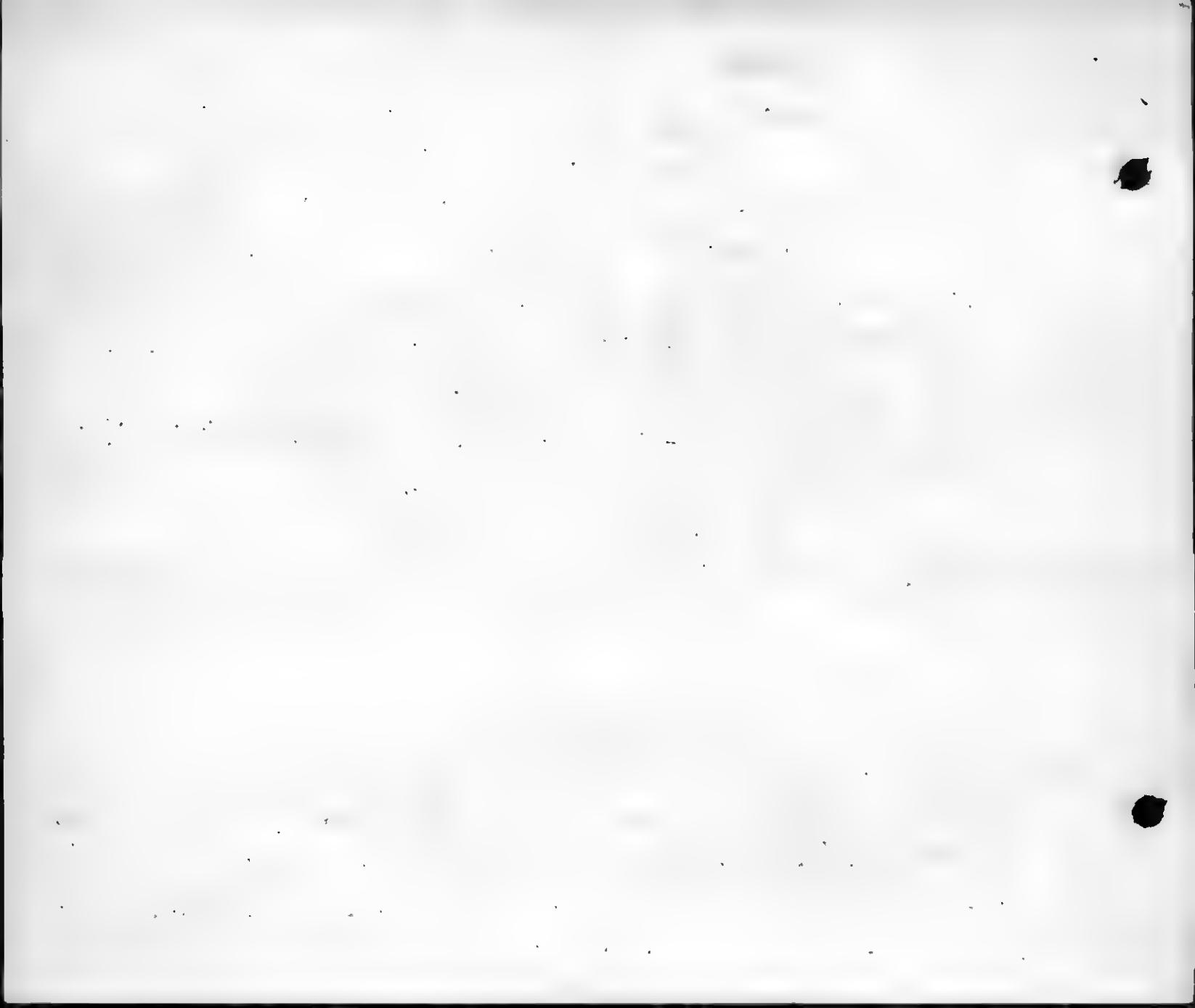
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | |
|---|--|---|--|--|---|---|------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | | c. LENGTH OF STAY IN 1b X 3 Mos. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | | d. STREET ADDRESS 714 Beall Ave. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 714 Beall Ave. | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) CHARLES | | First | Middle | Last | 4. DATE OF DEATH Nov. 13, | Month | Day | Year | |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH June 6, 1870 | 9. AGE (In years last birthday) 89 yrs. | IF UNDER 1 YEAR 5 | IF UNDER 24 HRS. 7 | Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lime Stone Worker | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (State or foreign country) Indiana | | 12. CITIZEN OF WHAT COUNTRY? U. S. | | | |
| 13. FATHER'S NAME Henry Baugh | | 14. MOTHER'S MAIDEN NAME Unknown | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 317-05-0555 | | INFORMANT Son Fred L. Baugh | | Address 203 Croydon Ave. Rockville, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 540.0 | | DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. { (b) | | <i>Gastric obstruction</i> <i>gastric ulceration</i> | | INTERVAL BETWEEN ONSET AND DEATH 1 wk | | | |
| DUE TO { (c) | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) Pul. Emphysema + ASHD | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) While at work | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| | | | | | | | | | |
| 21. I certify that I attended the deceased from 10/26/1957 to 11/13 , 1957, that I last saw the deceased alive on 11/15 , 1957, and that death occurred at 10:30 PM from the causes and on the date stated above. | | | | | | ADDRESS (Street, city or town, state) Rockville, Md. | | DATE SIGNED 11/14/57 | |
| ACTUAL SIGNATURE <i>Stephen N. Jones</i> | | PHYSICIAN'S NAME (Type) STEPHEN N. JONES | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit | | 22b. DATE THEREOF 11/18/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Presbyterian Church Cem. Ellettsville, Indiana | | 22d. LOCATION (City, town, or county) (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Maryland | | 24a. REC'D BY REGISTRAR DATE NOV 18 '59 | | 24b. REGISTRAR'S SIGNATURE <i>Albert S. Frank</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Reg. 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12711

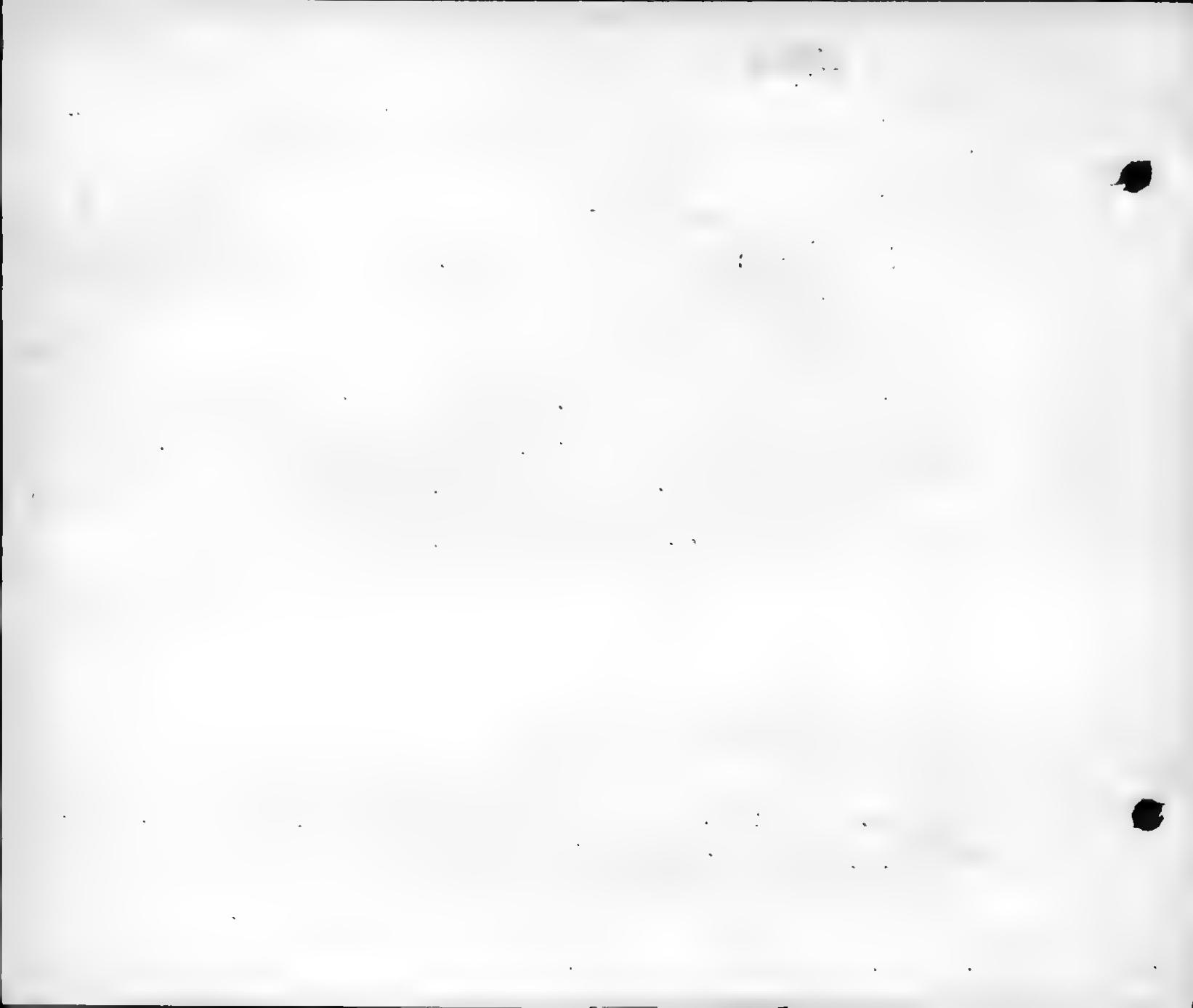
CERTIFICATE OF DEATH

Reg. Dist. No.

12672

TO HOSPITAL OR The hospital or attending physician may be retained.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|----------------------------------|---|-------------------------------------|--|---------------------------------------|---|---------------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | c. LENGTH OF STAY IN 1b 21 days | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) d. STATE MARYLAND | | b. COUNTY <i>Anne Arundel</i> | |
| b. C.TY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SHADYSIDE | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | First ELMER | Middle R | Last BAYNE | 4. DATE OF DEATH | Month Nov | Day 10 | Year 1959 |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/14/04 | 9. AGE (In years last birthday) 55 yrs. | IF UNDER 1 YEAR Months 5 | IF UNDER 24 HRS. Days 10 | Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yacht Club Mgr. | | 10b. KIND OF BUSINESS OR INDUSTRY Mgr. | | 11. BIRTHPLACE (State or foreign country) Tinton, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Hugh Richard Bayne. | | 14. MOTHER'S MAIDEN NAME Mary E Loveloss | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | INFORMANT Mrs Adry Bayne | | Address Shady Side, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Cerebral Hemorrhage ' 72 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Glomerulonephritis DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10-18 , 19 59 , to 11-10 , 19 59 , that I last saw the deceased alive on 11-10 , 19 59 , and that death occurred at 3 P.M. from the causes and on the date stated above. | | | | | | ADDRESS (Street, city or town, state) Washington Clinic, Wash. D.C. | |
| ACTUAL SIGNATURE Joseph A. Bailey, M.D. | | | | | | DATE SIGNED 11-10-59 | |
| PHYSICIAN'S NAME (Type) JOSEPH A. BAILEY M.D. | | | | | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF Nov-13th | | 22c. NAME OF CEMETERY OR CREMATORIAL GEODAR Hill | | 22d. LOCATION (City, town, or county) SHIPLAND MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros 1661 Good Hope Rd. Wash. D.C. | | ADDRESS Wash. D.C. | | 24a. REC'D BY REGISTRAR NOV 13 '59 | | 24b. REGISTRAR'S SIGNATURE James & Evans | |



1
X
h
X
I
C
2
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12673

Reg. Dist. No.

| | | | | | | | | |
|---|--|--|--|--|--|---|--------------------------|------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | b. COUNTY Montgomery | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase | | c. LENGTH OF STAY IN 1b 25 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase | | d. STREET ADDRESS 3517 Shepherd Street | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3517 Shepherd Street | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) ANNA YEATMAN | | First | Middle | Last | 4. DATE OF DEATH BEACH | Month | Day | Year |
| 5. SEX Female | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH July 30, 1864 | 9. AGE (In years last birthday) 95 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? U. S. | | |
| 13. FATHER'S NAME Robert Henry Yeatman | | | | 14. MOTHER'S MAIDEN NAME Mary Olivia Simpson | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Elva Gifford-Niece-same as 2d | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> | | | | | | | | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. 331X | | | | | | | | |
| DUE TO [b] | | | | | | | | |
| DUE TO (c) | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i> | | DATE SIGNED 11/30/59 | | | | | | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-2-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Oak Hill Cemetery | | 22d. LOCATION (City, town, or county) Washington, D. C. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE Dec 2 '59 | | 24b. REGISTRAR'S SIGNATURE <i>Caroline S. Trahan</i> | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

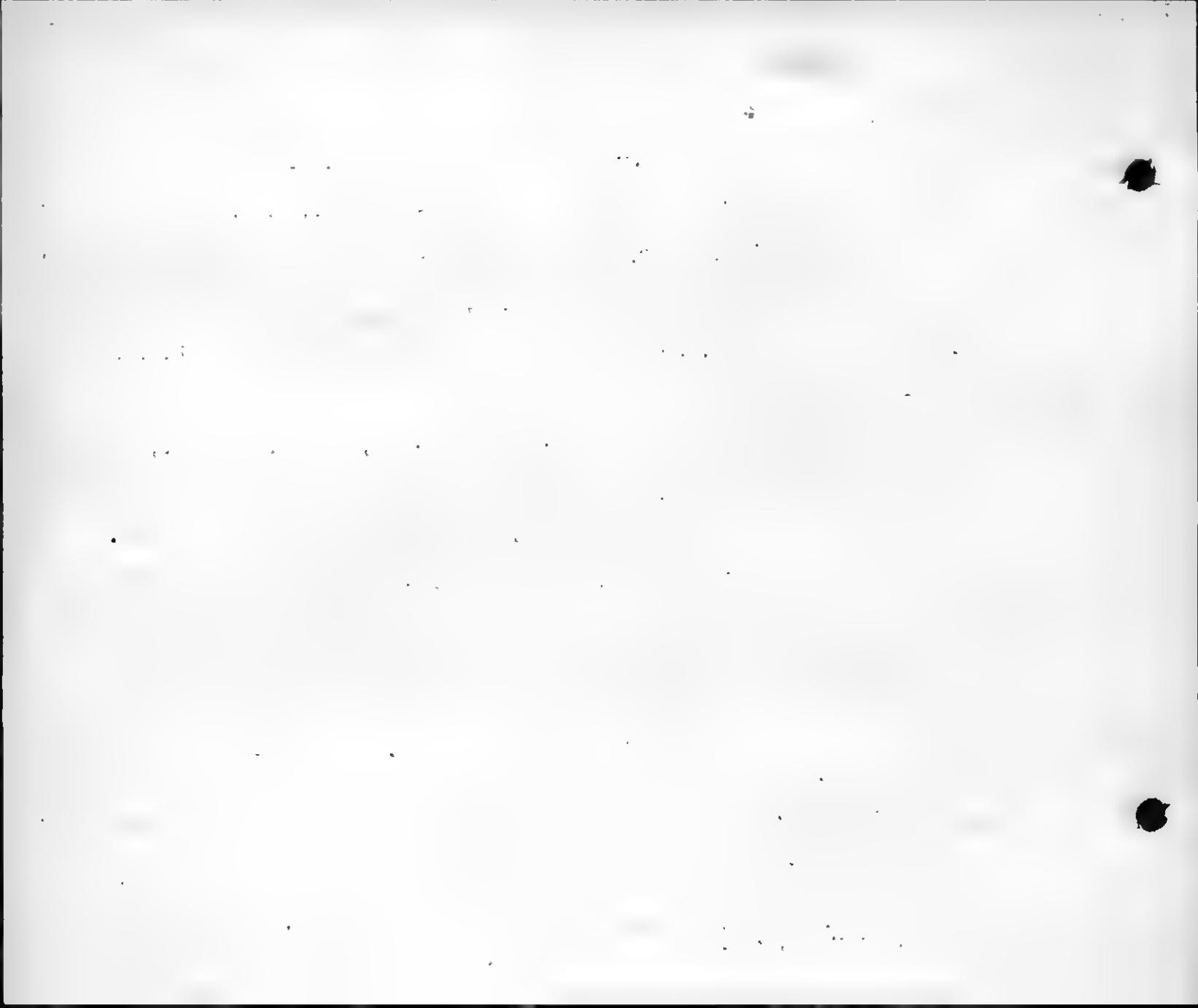
12674

12713

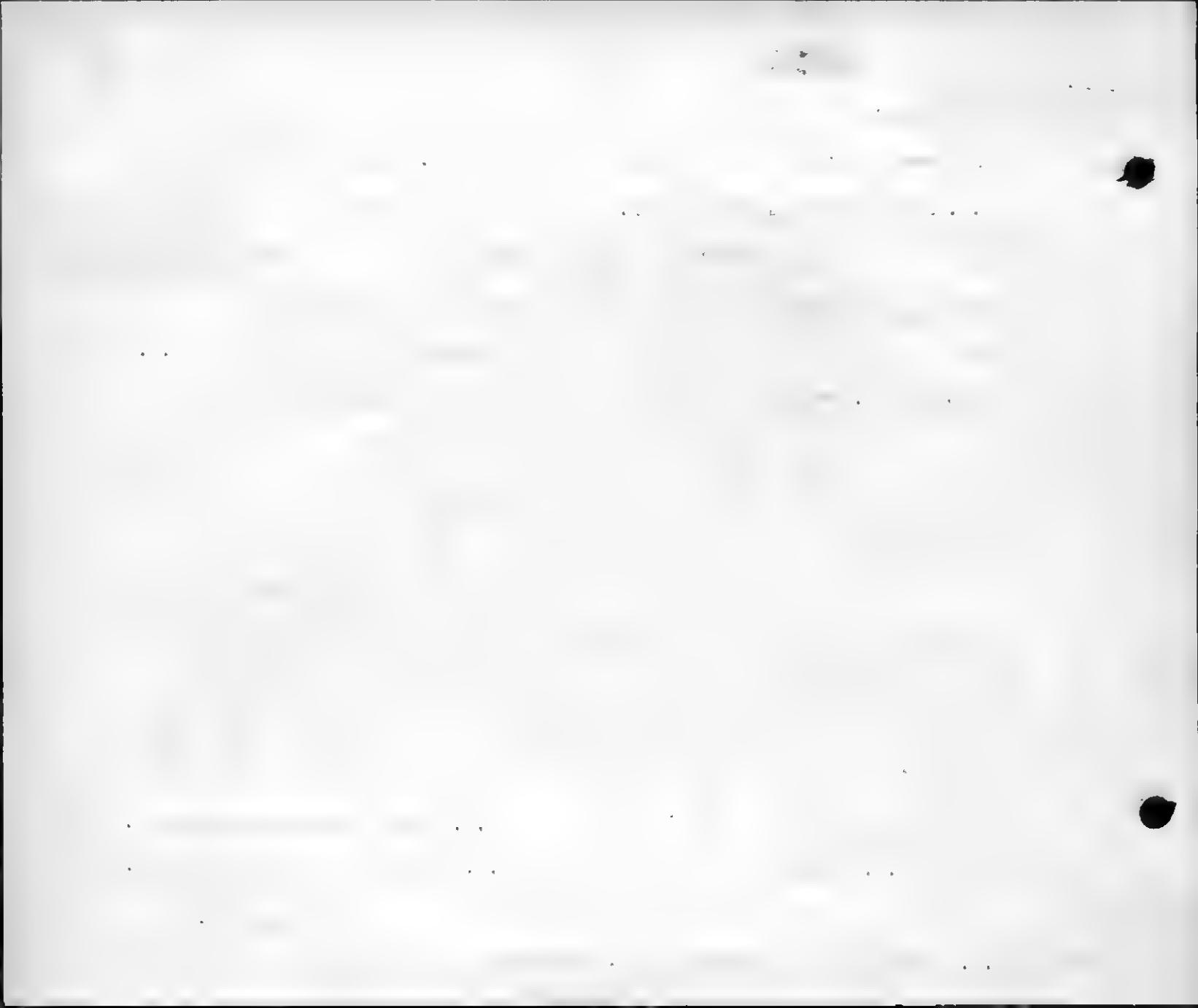
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | |
|--|----------------------------------|---|--|---|--|--|-------------------------------------|----------------------|-----------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE MARYLAND | | b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRLAND | | c. LENGTH OF STAY IN 1b 1 year | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D. C. | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAIRLAND NURSING HOME | | d. STREET ADDRESS 4535 - 30th ST., N. W. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) ARTHUR | | First C. | Middle | Last BEACH | 4. DATE OF DEATH NOVEMBER 14 | Month NOVEMBER | Day 14 | Year 19 59 | |
| S. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH DEC. 17, 1868 | | 9. AGE (In years last birthday) 90 yrs | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS Days 0 | Hours 0 | Min 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK | | 10b. KIND OF BUSINESS OR INDUSTRY U. S. GOVERNMENT | | 11. BIRTHPLACE (State or foreign country) MICHIGAN | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME ALVIN BEACH | | | | 14. MOTHER'S MAIDEN NAME ARVILLA BULLOCK | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | | INFORMANT Miss Sandra Beach, 1240 No. Quinn St., Arlington, Va. | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | | | | | | | |
| 420.1 DUE TO Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis (c) Generalized arteriosclerosis | | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH Sudden death | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from Nov 29 , 19 58 , to Nov 14 , 19 59 , that I lost sow the deceased alive on Oct 20 , 19 59 , and that death occurred at M. , from the causes and on the date stated above. | | | | | | | | | |
| ADDRESS (Street, city or town, state) 8237 Georgia Ave., Silver Spring, Md. | | | | | | | | | |
| DATE SIGNED Nov 18 1959 | | | | | | | | | |
| ACTUAL SIGNATURE Aaron H. Traum | | PHYSICIAN'S NAME (Type) AARON H. TRAUM | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Nov. 18, 1959 | | 22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery | | 22d. LOCATION (City, town, or county) Suitland, Maryland | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska, Inc. | | ADDRESS Silver Spring, Md. | | 24a. REC'D BY REGISTRAR Arthur S. Kraus | | 24b. REGISTRAR'S SIGNATURE | | | |
| VS A15 (4) 1SM 9/58 | | DATE NOV 18 '59 | | | | | | | |



| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | | | 12675 | | | |
|--|--|---|--|--|--|---|--|--|--|--------------------------|--|--|--|---------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | Reg. Dist. No. 215 | | | |
| 1. PLACE OF DEATH a. COUNTY Montgomery | | | | MARYLAND | | | | 2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE Maryland | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b 1 day | | | | d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort G. Meade | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL, BETHESDA MD. | | | | | | | | d. STREET ADDRESS 7229A Hall Street | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First Frederick | | Middle Roy | | Last BENSON | | 4. DATE OF DEATH | | Month November | | Day 13 | | Year 1959 | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| Male | | White | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11-17-56 | | 3 yrs | | Months 3 | | Days 0 | | Hours 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) GERMANY | | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 13. FATHER'S NAME FREDERICK R. BENSON | | | | | | 14. MOTHER'S MAIDEN NAME ARLENE FISHER | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. None | | | | INFORMANT Hospital Records | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Edema 3 hrs. | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Total Body Irradiation 5 hrs. | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) Acute Lymphatic Leukemia 9 mos. | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 12 November, 1959 , to 13 November, 1959 , that I last saw the deceased alive on 13 November, 1959 , and that death occurred at 3:45 PM , from the causes and on the date stated above. | | | | | | | | ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE <i>G.B. Avery</i> | | | | | | | | M.D. U.S. Naval Hospital, Bethesda Md. 11-14-59 | | | | | | | |
| PHYSICIAN'S NAME (Type) G.B. Avery LT MC USN | | | | U.S. Naval Hospital, Bethesda Md. | | | | | | | | | | | |
| 22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11-17-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Arlington National | | | | 22d. LOCATION (City, town, or county) Arlington, Va. | | | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>R.A. Pumphrey</i> | | | | ADDRESS R.A. Pumphrey 7557 Wisconsin Ave. Bethesda, Md. | | | | 24a. REC'D BY REGISTRAR NOV 19 '59 | | | | 24b. REGISTRAR'S SIGNATURE <i>Calvin S. Kraus</i> | | | |



may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

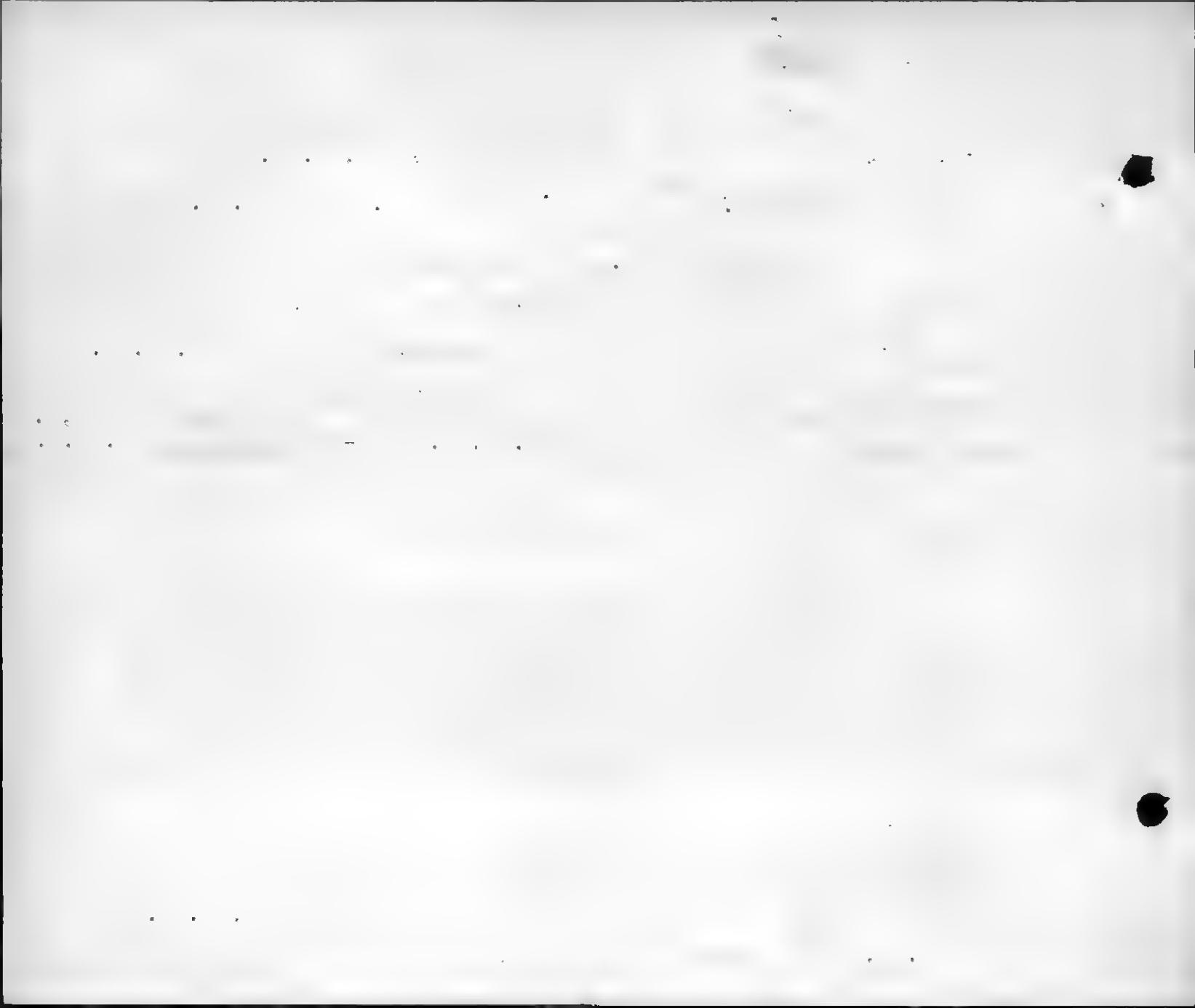
12676

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. _____

| | | | | | | | | | | | | | |
|---|--|---|---|---|---|--|--|--|------|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b RURAL | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. | | d. STREET ADDRESS 5420 Conn. Avenue N. W. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Congressional Manor San. 9200 Wisconsin Ave. | | d. STREET ADDRESS 5420 Conn. Avenue N. W. | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Lucy J. BERTHRONG | | First | Middle | Last | 4. DATE OF DEATH Nov. 10 1959 | | Month | Day | Year | | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/4/1863 | | 9. AGE (In years last birthday) 96 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12 CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | | | |
| 13. FATHER'S NAME John Jones | | 14. MOTHER'S MAIDEN NAME Rachael Jarboe | | INFORMANT Mrs. W. B. Hill-3933 Legation St. N.W. | | Address Washington, D.C. | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO (If yes, give war or dates of service) none | | 17. INFORMANT Mrs. W. B. Hill-3933 Legation St. N.W. | | INTERVAL BETWEEN ONSET AND DEATH 10 minutes | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Cerebral artery thrombosis INTERVAL BETWEEN ONSET AND DEATH 10 minutes | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO 5 years (c) | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20c. TIME OF INJURY Hour o. m. 19 p. m. | | Month, Day, Year | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.) | 20f. (City or town) (County) (State) | | | | | | | | |
| 21. I certify that I attended the deceased from July 7, 1948 , to Nov. 10, 1959 that I last saw the deceased alive on Oct. 26, 1959 , and that death occurred at 3 A.M. from the causes and on the date stated above. | | | | | | | | | | | | | |
| ADDRESS (Street, city or town, state) Thomas S. Sappington, M.D. 1025 Conn. Ave., N.W., Washington, D.C. | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Thomas S. Sappington</i> | | DATE SIGNED 10-12-59 | | | | | | | | | | | |
| PHYSICIAN'S NAME (Type) THOMAS S. SAPPINGTON | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/12/59 | 22c. NAME OF CEMETERY OR CREMATORIUM Rock Creek Cemetery | | 22d. LOCATION (City, town, or county) Washington, D. C. | | (State) | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company | | ADDRESS Washington, DC | 24a. REC'D BY REGISTRAR DATE NOV 12 '59 | | 24b. REGISTRAR'S SIGNATURE Cirius S. Traud | | | | | | | | |



12677

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

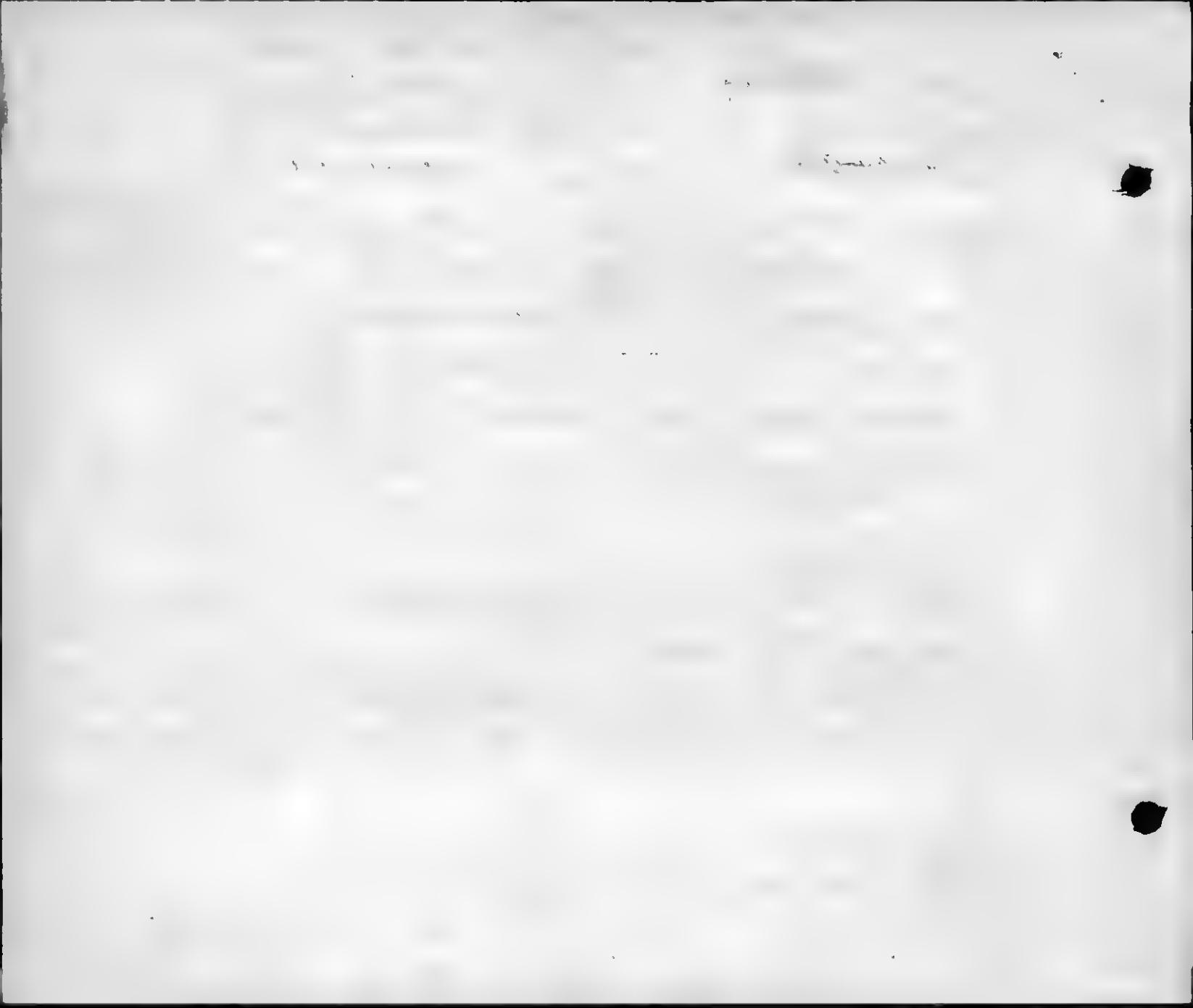
Reg. Dist. No.

12716

Item 21, Film G-253 12/14/59, cbc.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 1B. Give Pages 1, 2, and 3 to the funeral director. (Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 1 may be retained for your files.)
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the registrar prior to burial, cremation, or removal.

| | | | | | | | | | |
|--|--|--|--|--|--|---|-------------------------------------|-----------------------|-------------------|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN lb | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | |
| <i>Montgomery</i> | | <i>Bethesda</i> | | <i>3 yrs</i> | | d. STATE <i>MD</i> b. COUNTY <i>MONTG</i> | | | |
| | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | |
| | | | | | | <i>Bethesda</i> | | | |
| | | | | | | d. STREET ADDRESS <i>4518 Rockbury Dr</i> | | | |
| 3. NAME OF DECEASED (Type or print) | | First <i>Douglas Lee</i> | Middle <i>Bizzell</i> | Last <i>Bizzell</i> | 4. DATE OF DEATH | Month <i>11</i> | Day <i>10</i> | Year <i>1959</i> | |
| 5. SEX <i>Male</i> | | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <i>11-21-43</i> | 9. AGE (In years last birthday) <i>15 yrs.</i> | IF UNDER 1YEAR Months <i>1</i> | IF UNDER 24 HRS. Days <i>0</i> | Hours <i>0</i> | Min. <i>0</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School</i> | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) <i>N.C.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | |
| 13. FATHER'S NAME <i>Oscar Bizzell</i> | | 14. MOTHER'S MAIDEN NAME <i>Virginia Lohre</i> | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>None</i> | | 17. INFORMANT <i>Oscar Bizzell (father)</i> | | Address <i>111-2</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia by Hanging</i> DUE TO <i>136.0</i> INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) _____ | | | | | | | |
| | | (c) _____ | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Himself is back down at home</i> | | | | | | | |
| 20c. TIME OF INJURY Hour <i>a. m.</i> <i>p. m.</i> | | Month, Day, Year <i>19</i> | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i> | | 20f. (City or town) <i>Bethesda</i> | (County) <i>Monta</i> | (State) <i>Md</i> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE <i>Frank J. Breschart</i> | | DATE SIGNED <i>11-10-59</i> | | | | | | | |
| EXAMINER'S NAME (Type) <i>FRANK J. BRESCHART</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Bur. transit</i> | | 22b. DATE THEREOF <i>11/11/59</i> | | 22c. NAME OF CEMETERY OR CREMATORIUM <i>Hillcrest Cemetery</i> | | 22d. LOCATION (City, town, or county) <i>Newton Grove, N. Carolina</i> | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i> | | ADDRESS <i>Bethesda, Maryland</i> | | 24a. REC'D BY REGISTRAR DATE <i>NOV 12 '59</i> | | 24b. REGISTRAR'S SIGNATURE <i>C. Louis S. Kraus</i> | | | |



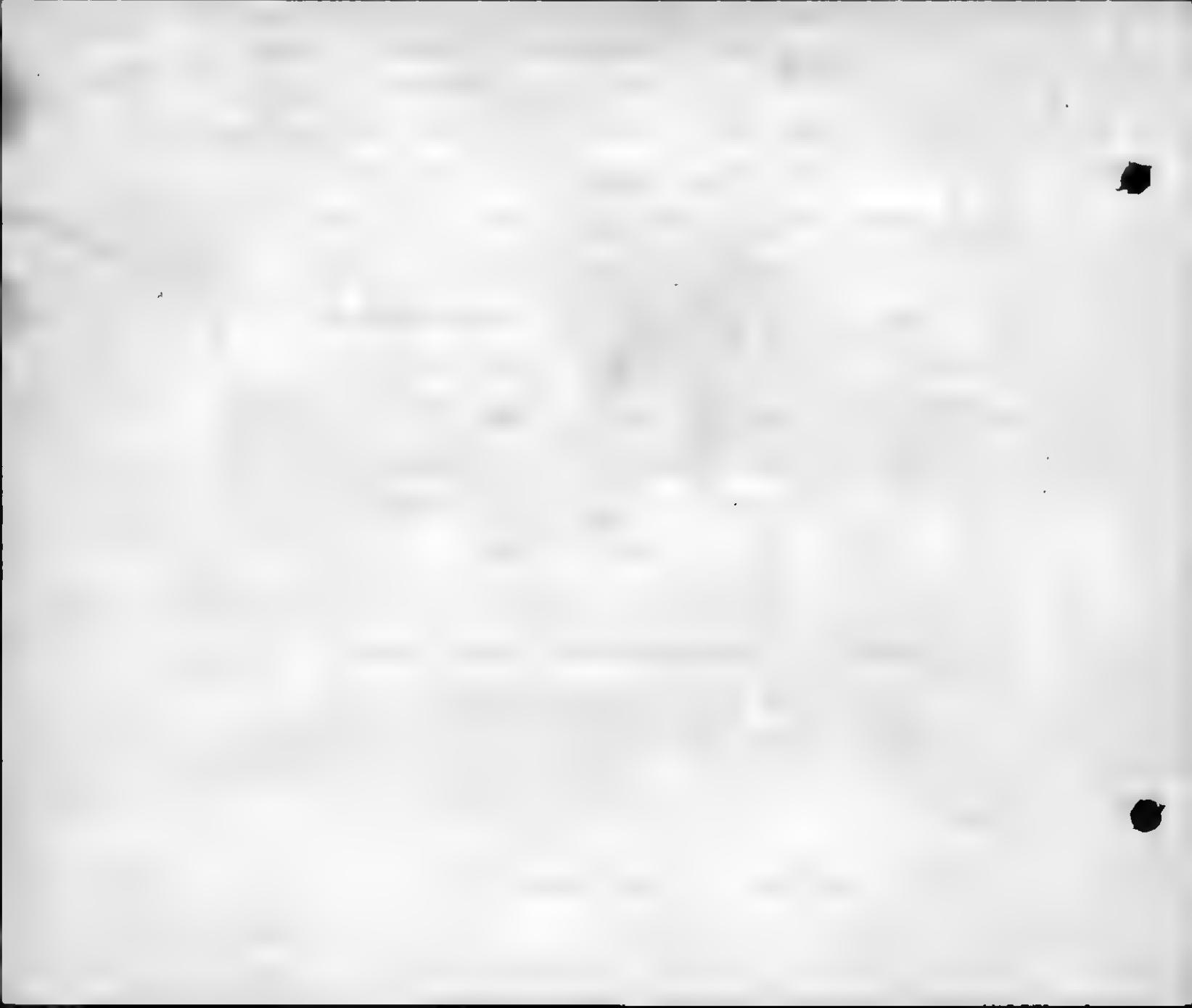
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12678

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) | |
| <i>Montgomery</i> <i>MARYLAND</i> | | a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> | |
| c. LENGTH OF STAY IN 1b <i>104.</i> | | d. STREET ADDRESS <i>8605 Mayfair Place</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sav. & Hosp</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Theodore Herman Bonk</i> | | First | Middle |
| 4. DATE OF DEATH <i>November 26 1959</i> | | Last | Month Day Year |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>JAN 19 1907</i> |
| 9. AGE (in years last birthday) <i>52 yrs.</i> | | 10. IF UNDER 16 YEARS Months <i>0</i> Days <i>0</i> | 11. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Neon Contractor</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. GOVERNMENT</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Miss. MINNESOTA</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>John Bonk</i> | | 14. MOTHER'S MAIDEN NAME <i>Mary Bleisi</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i> | | 16. SOCIAL SECURITY NO. <i>W.W.II</i> | |
| 17. INFORMANT <i>Alice Bonk - Ida 2</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>3x</i> | | <i>Thrombocytopenia</i> | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i> | | <i>Crusted chest</i> | |
| DUE TO <i>(c)</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Driver of car which failed to make curve & struck tree</i> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>12:30 p.m. 11-26 1959</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i> |
| | | 20f. (City or town) <i>Boltsville</i> | (County) <i>Monty</i> (State) <i>Md</i> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| MEDICAL CERTIFICATION SIGNATURE <i>Frank J. Bloschert</i> | | DATE SIGNED <i>11-26-59</i> | |
| EXAMINER'S NAME (Type) <i>FRANK J. Bloschert</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 12/1/59</i> | | 22b. DATE THEREOF <i>11-26-59</i> | |
| 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Arlington</i> | | 22d. LOCATION (City, town, or county) <i>Arlington</i> (State) <i>Va.</i> | |
| 22e. FUNERAL DIRECTOR'S SIGNATURE <i>Timothy Hauck - 3831-G Ave.</i> | | 24a. REC'D BY REGISTRAR DATE DEC 7 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12679

| | | | |
|--|-----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | c. LENGTH OF STAY IN 1b D.O.A. | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 25 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban | | d. STREET ADDRESS 5901 Belle Grove Rd. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |

| | | | | | | | |
|-------------------------------------|-------------|--------|------------|------------------|----------|--------|-----------|
| 3. NAME OF DECEASED (Type or print) | First Clyde | Middle | Last Boone | 4. DATE OF DEATH | Month 11 | Day 21 | Year 1959 |
|-------------------------------------|-------------|--------|------------|------------------|----------|--------|-----------|

| | | | | | | |
|-------------|--------------------------|---|-----------------------------|---|---------------------------|------------------------------------|
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/14/19 | 9. AGE (In years last birthday) 40 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Days Hours Min. |
|-------------|--------------------------|---|-----------------------------|---|---------------------------|------------------------------------|

| | | | |
|---|---|---|---------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer | 10b. KIND OF BUSINESS OR INDUSTRY Road construction | 11. BIRTHPLACE (State or foreign country) N. C. | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
|---|---|---|---------------------------------------|

| | |
|-------------------------------|---------------------------------|
| 13. FATHER'S NAME Wiley Boone | 14. MOTHER'S MAIDEN NAME Pierce |
|-------------------------------|---------------------------------|

| | | |
|---|------------------------------------|--|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. 45-1234567 | 17. INFORMANT Rose Lee Boone - wife - Same Address |
|---|------------------------------------|--|

| | | |
|--|--|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion | | Sudden |
| DUE TO | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b) | | |
| DUE TO | | |
| (c) | | |

| | | |
|--|--|---|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? |
| Collapsed while working on road construction | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

| | | | |
|---|--|--|--|
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
|---|--|--|--|

| | | | | | | |
|--|------------------------|---|--|---------------------|----------|---------|
| 20c. TIME OF INJURY Hour a. m. p. m. | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
|--|------------------------|---|--|---------------------|----------|---------|

| | | | | | | |
|---|--|--|--|--|--|--|
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | |
|---|--|--|--|--|--|--|

| | | |
|------------------------------------|--|-------------|
| ACTUAL SIGNATURE Frank J. Brummett | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | DATE SIGNED |
| EXAMINER'S NAME (Type) | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |

| | | | |
|--|----------------------------|---|---|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 11/25/59 | 22c. NAME OF CEMETERY OR CREMATORIAL Fayetteville, N.C. | 22d. LOCATION (City, town, or county) (State) |
|--|----------------------------|---|---|

| | | | |
|--|---------------------------|-------------------------|----------------------------|
| 23. FUNERAL DIRECTOR'S SIGNATURE John G. Stewart | ADDRESS 30 H Street, N.E. | 24a. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE |
| | | DATE NOV 25 '59 | Cecil S. Evans |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12680

Reg. Dist. No.

12718

| | | | | | | | | |
|--|---|--|---|--|--|---|------------------|----------------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY | | c. LENGTH OF STAY IN 1b 15 MIN. | | b. COUNTY MONTGOMERY | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY COUNTY GENERAL HOSPITAL, INC. | | | | d. STREET ADDRESS BONIFANT ROAD | | | | |
| 3. NAME OF DECEASED (Type or print) | | First MARY | Middle PEARL | Last BOWIE | 4. DATE OF DEATH | Month NOVEMBER | Day 13 | Year 19 59 |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH 1/23/95 | 9. AGE (in years last birthday) 64 83X yrs. | IF UNDER 1 YEAR Months 64 | IF UNDER 24 HRS. Days 83X | Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY own home | | 11. BIRTHPLACE (State or foreign country) REXTON-NEW BRUNSWICK | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME J. P. KINREAD | | | | 14. MOTHER'S MAIDEN NAME Pearl Simmons | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT HOSPITAL RECORDS | | Address OLNEY, MARYLAND | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) MASSIVE SUB-DURAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO CEREBRO-VASCULAR ACCIDENT DUE TO (c) | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 2 HRS. | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE <i>Franck J. Broschart</i> | DATE SIGNED 11/13/59 | | | | | | | |
| EXAMINER'S NAME (Type) F. J. BROSCHEART, M. D. | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 11/17/59 | 22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NATIONAL CEMETERY | 22d. LOCATION (City, town, or county) ARLINGTON, VIRGINIA | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. FUMPERKEY, INC. <i>Howard A. Zukas</i> | ADDRESS SILVER SPRING, MD. | 24a. REC'D BY REGISTRAR NOV 18 '59 | 24b. REGISTRAR'S SIGNATURE <i>Elisabeth S. Kraus</i> | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

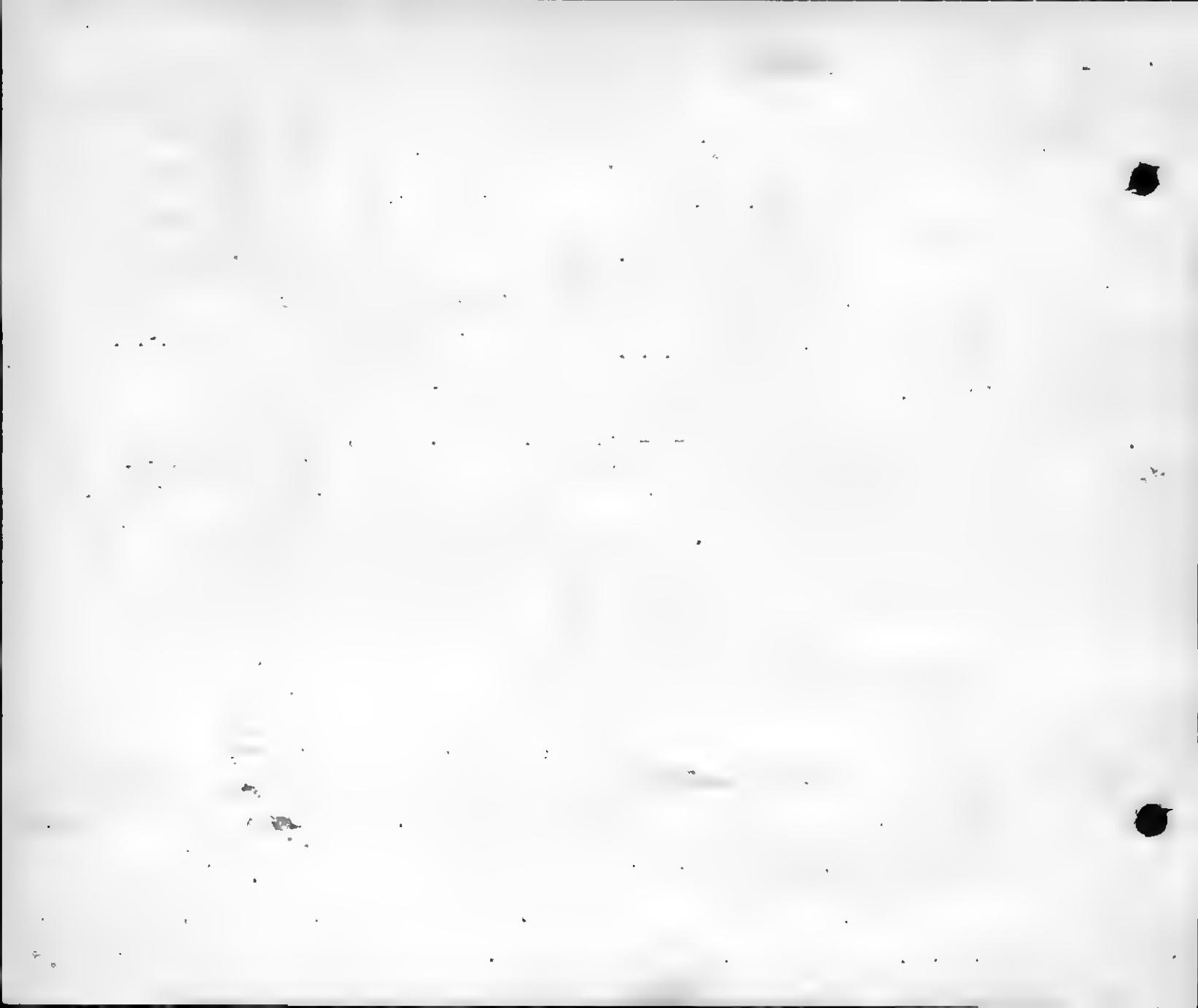
12719

CERTIFICATE OF DEATH

Reg. Dist. No.

12681

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | |
| c. LENGTH OF STAY IN 1b 20 yrs. | | d. STREET ADDRESS 8806 COLESVILLE ROAD | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8806 COLESVILLE ROAD | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First JAMES | Middle R. | Last BRITT |
| 4. DATE OF DEATH | Month NOV. | Day 21 | Year 19 59 |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/28/95 |
| 9. AGE (In years lost birthday) 63 yrs. | 10. IF UNDER 1 YEAR Months 63 | 11. IF UNDER 24 HRS. Days 0 | 12. IF UNDER 24 HRS. Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHIEF OF REPORT SECTION | 10b. KIND OF BUSINESS OR INDUSTRY I.C.C. | 11. BIRTHPLACE (State or foreign country) NORTH CAROLINA | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME GEORGE P. BRITT | 14. MOTHER'S MAIDEN NAME LOUISE ROBERTS | Address Silver Spring, Maryland | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | 16. SOCIAL SECURITY NO. 718-12-0553 | INFORMANT Mrs. Eula F. Britt, 8806 Colesville Road | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH Immediate 4 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO arteriosclerotic Heart Disease (c) DUE TO 6 years | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 59 | | | |
| 21. I certify that I attended the deceased from 8/22/1954 to 11/21/1969 , that I last saw the deceased alive on 11/21/1969 and that death occurred at 8:57 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Russell B. Arnold, M.D. ADDRESS (Street, city or town, state) 8801 Colesville Road, 11/21/69 DATE SIGNED 11/21/69 | | | |
| PHYSICIAN'S NAME (Type) Russell B. Arnold, M.D. | | | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) BURIAL & Transit | 22b. DATE THEREOF 11/24/59 | 22c. NAME OF CEMETERY OR CREMATORIUM PARK MEMORIAL CEMETERY | 22d. LOCATION (City, town, or county) x (State) NORTH WILKSBORO, NORTH CAROLINA |
| 23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Warner | ADDRESS WARNER E. PUMPHREY, INC. | 24a. REC'D BY REGISTRAR DATE NOV 24 '59 | 24b. REGISTRAR'S SIGNATURE Arthur S. Evans |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12682

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | |
|---|--|--|---|---|--|
| Weight <u>6 lbs</u> <u>1 lb. 3 oz.</u> | | 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> | | c. LENGTH OF STAY IN 1b <u>15 hrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u> | | e. STREET ADDRESS <u>Rockville C-15</u> | | f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Baby Girl, CARTER</u> | | First | Middle | Last | 4. DATE OF DEATH <u>NOVEMBER 15 1959</u> |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>NOVEMBER 15 1959</u> | 9. AGE (In years last birthday) yrs. <u>14</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | | |
| 13. FATHER'S NAME <u>George FRANKLIN Carter</u> | | 14. MOTHER'S MAIDEN NAME <u>Dorothy Riley</u> | | Address | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | PREMATURITY | | INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>11/15</u> , 19 <u>59</u> , to <u>11/15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/15</u> , 19 <u>59</u> , and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above ACTUAL SIGNATURE <u>John Franklin</u> M.D. | | | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation Nov. 18-59 | | 22b. DATE THEREOF Nov. 18-59 | | 22c. NAME OF CEMETERY OR CREMATORIAL <u>Suburban Hospital Old Boro Town Rd. Bethesda</u> | |
| 22d. LOCATION (City, town, or county) (State) | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Suburban Hospital</u> | | ADDRESS <u>3600 Old Garrison Rd.</u> | | 24a. REC'D BY REGISTRAR DATE NOV 23 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retain by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

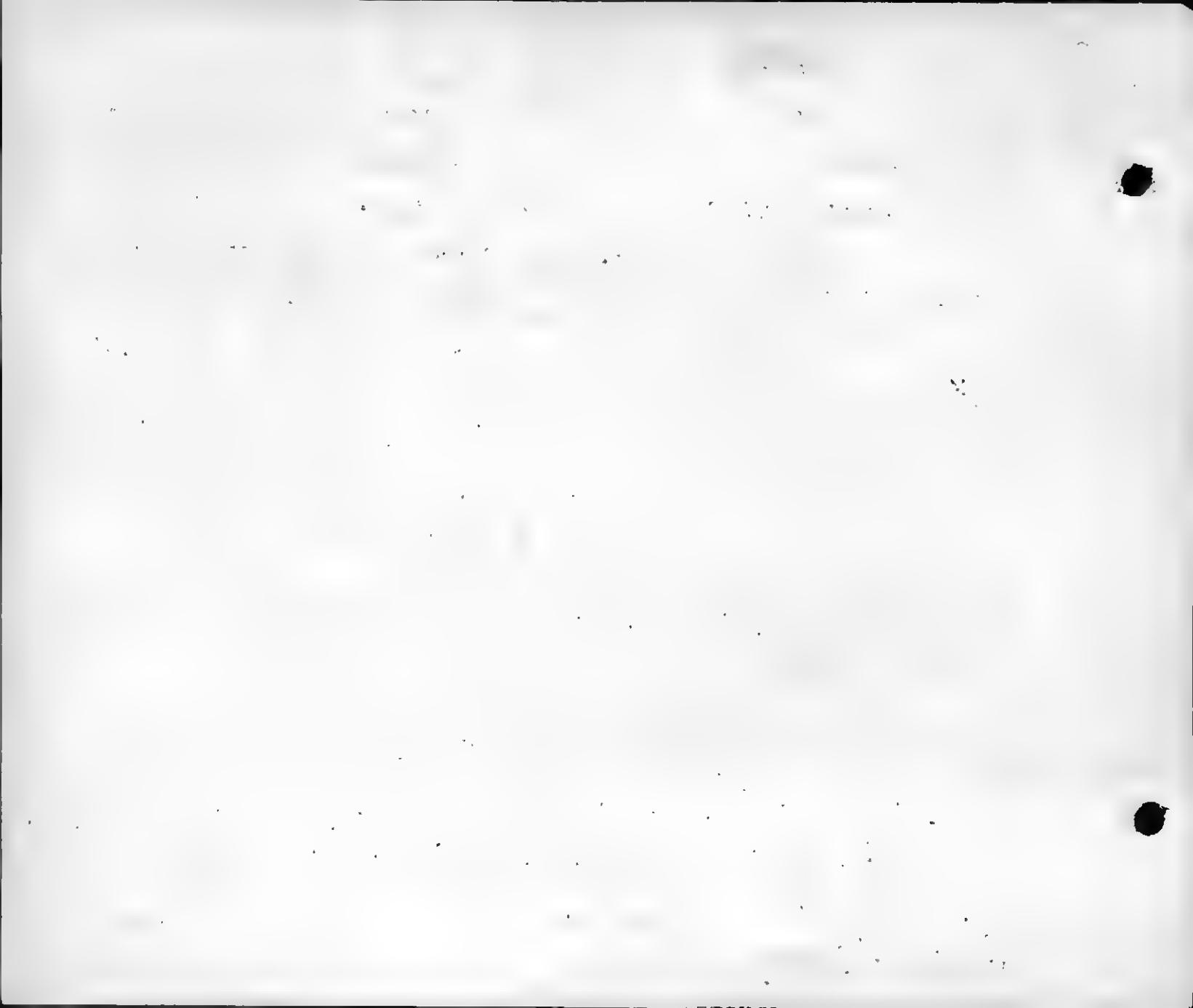
12683

12721

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH o COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN lb X Bethesda | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 074 | |
| 3. NAME OF DECEASED (Type or print) | First Madge | Middle P. | Last Carter |
| S. SEX Female | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 3/20/74 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY — | |
| 11. BIRTHPLACE (State or foreign country) Toria | | 12. CITIZEN OF WHAT COUNTRY? U. S. A | |
| 13. FATHER'S NAME K. J. Presney | 14. MOTHER'S MAIDEN NAME Gilliland | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. none | INFORMANT Daughter Madge C. Goolsby | Address Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42a1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Coronary thrombosis. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I(a) Arteriosclerotic gangrene, R. feet. | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) — | |
| 20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ADDRESS DATE SIGNED 11/4/1959 | | | |
| ACTUAL SIGNATURE Robert A. Humphrey | PHYSICIAN'S NAME (Type) Robert A. GRANT M.D. | 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | |
| 22b. DATE THEREOF 11/7/59 | 22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory | 22d. LOCATION (City, town, or county) Suitland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey | ADDRESS Bethesda, Maryland | 24a. REC'D BY REGISTRAR DATE NOV 6 '59 | 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

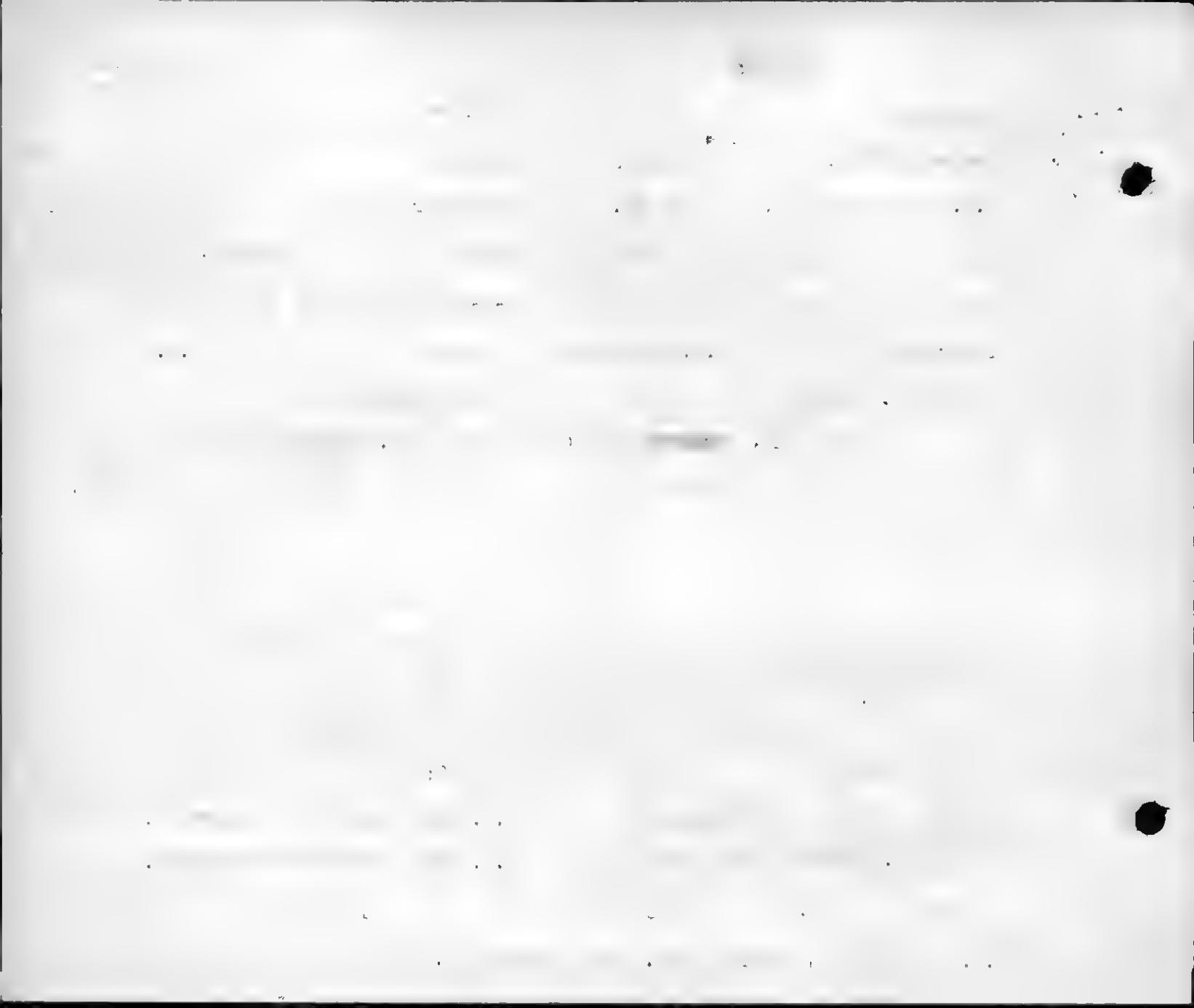
12684

12722

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | | | | | |
|---|---------------------------------|---|--|---|---|---|-------------------------------------|---------------------|------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) STATE Maryland | | b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN lb 57 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | d. STREET ADDRESS 56111 Durbin Road | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md. | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Steven | | First IV | Middle " | Last CARTER | 4. DATE OF DEATH November 4 1959 | Month November | Day 4 | Year 1959 | |
| S SEX Male | 6 COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH 10-8-15 | 9. AGE (in years last birthday) 44 | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS Days 0 | Hours 0 | Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Congressman | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Government | | 11 BIRTHPLACE (State or foreign country) Utah | | 12 CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 13. FATHER'S NAME Joseph T. CARTER | | | | 14. MOTHER'S MAIDEN NAME Effie STEVENS | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO (If yes, give war or date of service) 1943 to 1946 481 12 1057 | | INFORMANT (Wife) Lucille K. Carter Same as #2 | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b) Lymphoscaroma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) | | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 2 years | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 8 September, 1959 , to 4 November, 1959 that I last saw the deceased alive on 4 November, 1959 , and that death occurred at 2:07A M, from the causes and on the date stated above. | | | | | | | | | |
| ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. | | | | | | | | | |
| DATE SIGNED 11-4-59 | | | | | | | | | |
| ACTUAL SIGNATURE G. Walker Capt MC USA | | | | | | | | | |
| PHYSICIAN'S NAME (Type) G. WALKER CAPT MC USA | | | | | | | | | |
| U.S. Naval Hospital, Bethesda Md. | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11-7-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Leon | | 22d. LOCATION (City, town, or county) Leon Iowa | | (State) | |
| 23. FUNERAL DIRECTORY SIGNATURE W.E. Pumphrey | | ADDRESS 8434 Georgia Ave. Silver Spring Md. | | 24a. REC'D BY REGISTRAR NOV 6 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Krause | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician and completely filled in by the attending physician and signed by the attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12685

12723

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 12hrs. 45 min. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton | |
| 3. NAME OF DECEASED (Type or print) Mary | | First Mary | Middle Elizabeth |
| Last Chupek | | 4. DATE OF DEATH 11 19 1959 | Month Day Year |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/18/59 |
| 9. AGE (In years last birthday) yrs 12 | | 10. IF UNDER 1 YEAR Months 12 | 11. IF UNDER 24 HRS Days Hours Min 59 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant | | 10b. KIND OF BUSINESS OR INDUSTRY none | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Michael Vincent Chupek | | 14. MOTHER'S MAIDEN NAME Betty Mary Gordosik | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | |
| INFORMANT Michael V. Chupek — above (Father) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Improperly functioning respiratory center (cranial) 13 hrs. | | | |
| DUE TO 762. | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity 13 hrs. | | | |
| DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 18 Nov. 1959 to 19 Nov. 1959 that I last saw the deceased alive on 19 Nov. 1959 , and that death occurred at 7:54 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>L. Marshall Cuvillier Jr. MD.</i> | | ADDRESS (Street, city or town, state) 1407 Woodside Pkwy, Silver Spring, Md. | |
| PHYSICIAN'S NAME (Type) L. MARSHALL CUVILLIER, JR. | | DATE SIGNED 11/19/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 11/20/59 | 22c. NAME OF CEMETERY OR CREMATORIUM GATE OF HEAVEN CEMETERY |
| | | 22d. LOCATION (City, town, or county) MONTGOMERY COUNTY, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Gruka</i> | | 24a. REC'D BY REGISTRAR NOV 24 '59 | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> |
| VS A1S (4) 1SM 9/58 | | | |



TO HOSPITAL or **ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by me funeral director, page 3 should be detached for use as the burial-transit permit. Then ~~please~~ remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

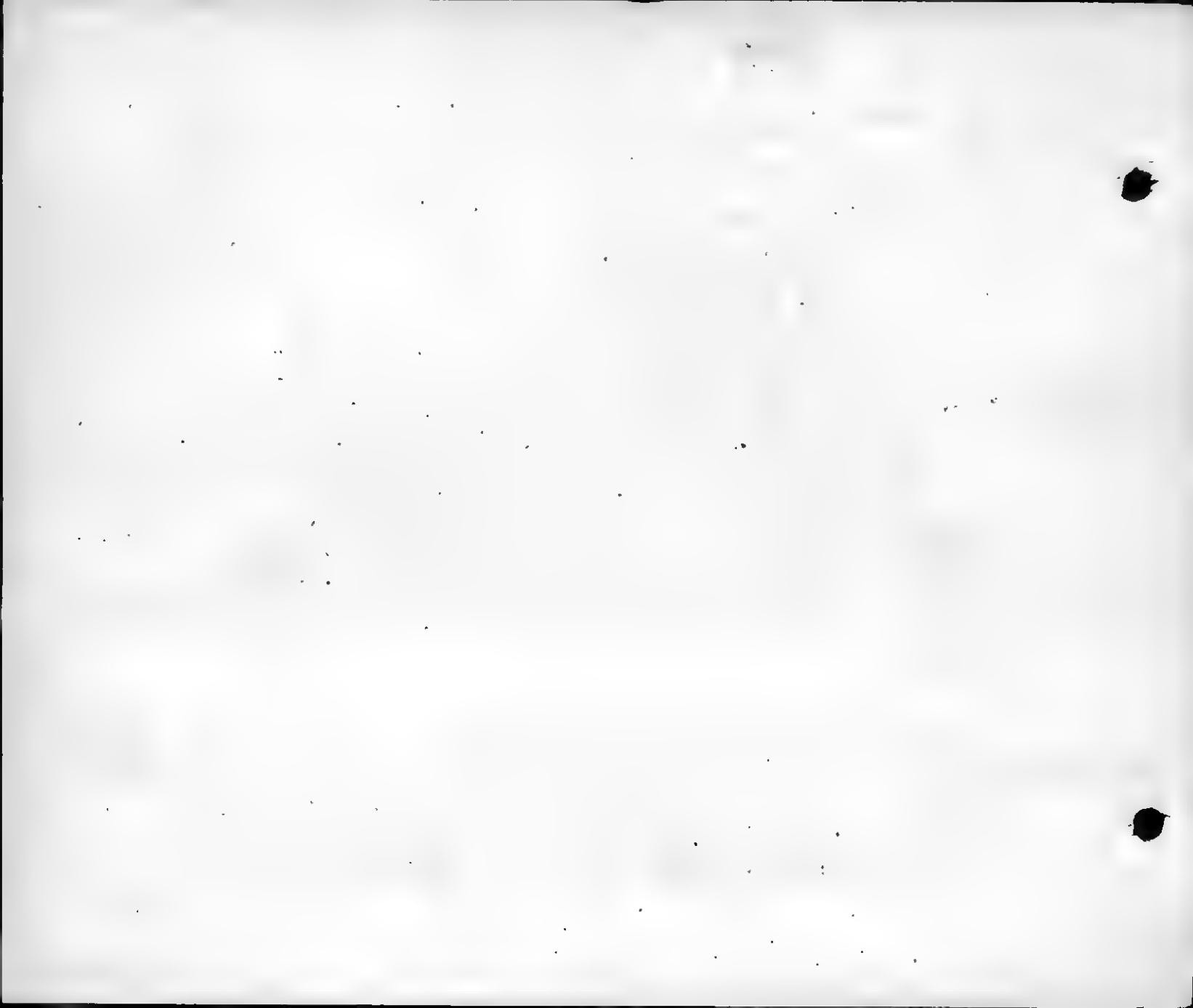
12724

CERTIFICATE OF DEATH

Reg. Dist. No.

12686

| | | | | | | | |
|---|----------------------------------|---|------------------------------------|--|---|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland | | b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 6 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban | | d. STREET ADDRESS 4708 Oxbow Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First Edward | Middle F. | Last Clark | 4. DATE OF DEATH 11 | Month 11 | Day 11 | Year 19 59 |
| 5. SEX MALE. | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/10/94 | 9. AGE (In years last birthday) 65 yrs. | 10. IF UNDER 1 YEAR Months 0 | Days 0 | Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Bethesda, New York | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME MICHAEL | | 14. MOTHER'S MAIDEN NAME CLARK | | INFORMANT Cecelia L Clark | | Address Same as | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes | | 16. SOCIAL SECURITY NO. COAST GUARD | | 17. INTERVAL BETWEEN ONSET AND DEATH 1 hr. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia | | | | | | | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b) Circulatory system DUE TO (c) Pneumonia | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bacterial infection | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) By bacterial infection | | 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that I attended the deceased from 11/2/1959 to 11/4/1959 that I last saw the deceased alive on 11/4/1959 , and that death occurred at 5:30 AM , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) Rockville, Md. | | | | | | | |
| DATE SIGNED 11/4/59 | | | | | | | |
| ACTUAL SIGNATURE Stephen N. Jones | | | | | | | |
| PHYSICIAN'S NAME (Type) Stephen N. Jones | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11-14-1959 | | 22c. NAME OF CEMETERY OR CREMATORIUM Washington Hall | | 22d. LOCATION (City, town, or county) Rockville, Md. | |
| (State) | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE S. G. Mattingly | | ADDRESS Wash. D.C. | | 24a. REC'D BY REGISTRAR NOV 13 59 | | 24b. REGISTRAR'S SIGNATURE Colvin & Sons | |
| (Date) | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12687

Item 2C Film 253 12-2-59 ams

CERTIFICATE OF DEATH

Reg. Dist. No. 215

12725

PLACE OF DEATH

a. COUNTY
Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

c. LENGTH OF STAY IN lb

9 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

U.S. Naval Hospital, Bethesda Md.

2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)

a. STATE
Maryland

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Clinton

d. STREET ADDRESS

Box 349 Woodyard Road

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
ClarenceMiddle
HerbertLast
COLE4. DATE
OF
DEATHMonth
NovemberDay
12
Year
1959

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

IF UNDER 1 YEAR IF UNDER 24 MRS

Male

White

WIDOWED DIVORCED

7-24-90

Months

Days

Hours

Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

U.S. Navy

10b. KIND OF BUSINESS OR INDUSTRY

U.S. Government

11. BIRTHPLACE (State or foreign country)

Colorado

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Carmen COLE

14. MOTHER'S MAIDEN NAME

Sadie LEWIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

Yes

16. SOCIAL SECURITY NO. (If yes, give war or dates of service)

WW I & II

INFORMANT

(Wife) Elsie Cole

Address

Same as #2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

intracerebral hematoma

INTERVAL BETWEEN
ONSET AND DEATH
2 weeksConditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.
900.9

DUE TO

(b)

DUE TO

(c)

cerebral contusion and laceration

2 weeks

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner)20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
Reportedly fell down six stairs and received a head injury20c. TIME OF INJURY Month, Day, Year
Hour X 24%
6:30 p.m. 10-26-5920d. INJURY OCCURRED
While at work Not while at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Unknown20f. (City or town)
Unknown

(County)

(State)

21. I certify that I attended the deceased from 3 November 1959, to 12 November 1959, that I last saw the deceased alive on 12 November 1959, and that death occurred at 9:30A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Matthew William Wood, M.D. U.S. Naval Hospital, Bethesda Md. 11-12-59

PHYSICIAN'S
NAME (Type)

U.S. Naval Hospital, Bethesda Md.

22a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial22b. DATE THEREOF
11-17-5922c. NAME OF CEMETERY OR CREMATORY
Arlington National22d. LOCATION (City, town, or county)
Arlington Va.

(State)

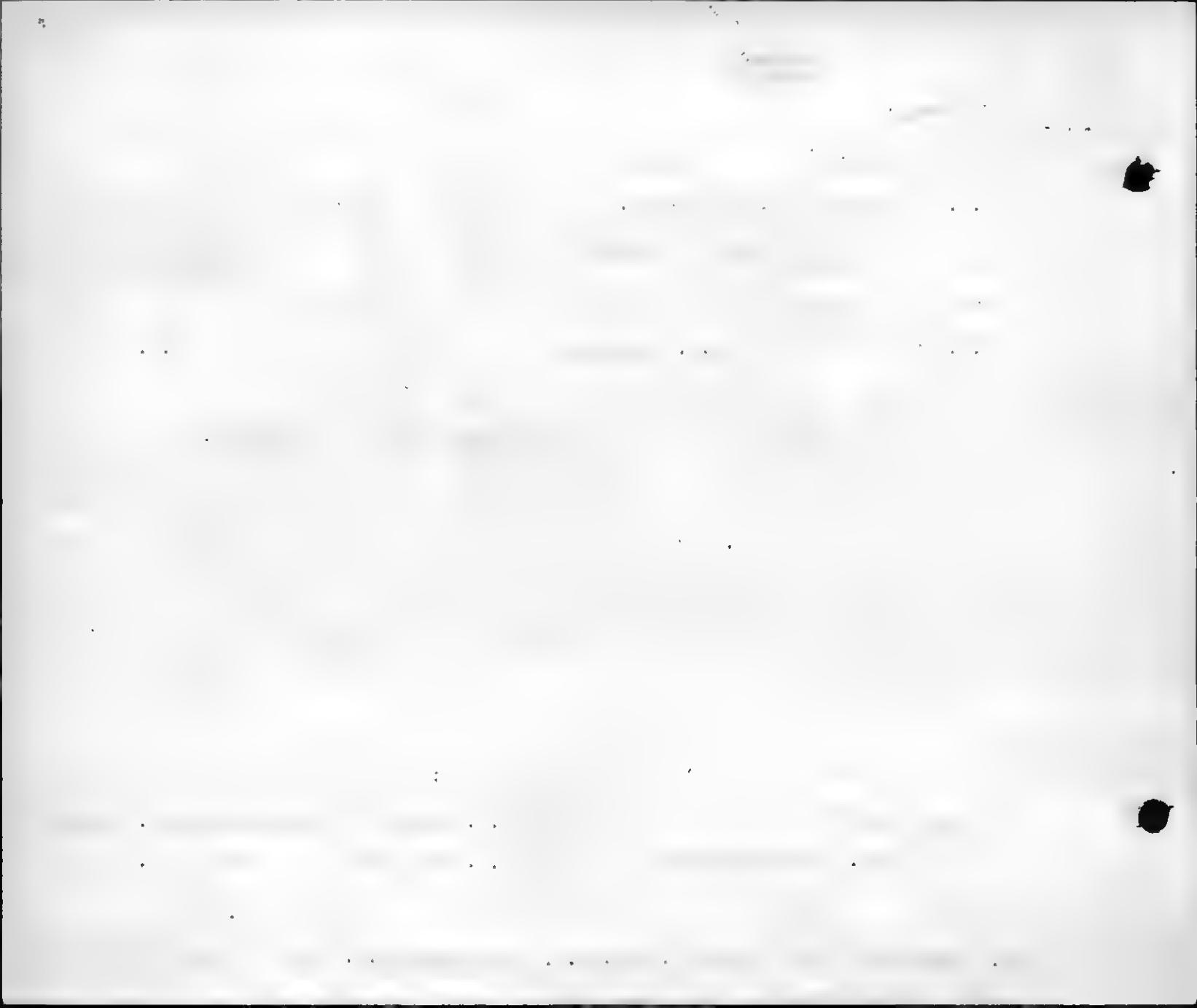
23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS
J. Gawlers and Sons 1756 Penn. Ave. N.W. Washington, D.C. 1959

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Catherine S. Thomas



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12688

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12675

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Washington Sanitarium + Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

d. STREET ADDRESS

1867 Piney Branch Rd.

e. IS RESIDENCE ON A FARM?
YES NO 3. NAME OF DECEASED
(Type or print)

First Elinor

Middle Mavis

Last Cope

4. DATE OF DEATH

Month 11

Day 8

Year 1959

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

7/31/84

9. AGE (in years last birthday)

76 yrs.

10. IF UNDER 1 YEAR

Months

Days

Hours

Min.

11. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own home

11. BIRTHPLACE (State or foreign country)

Canada

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Amos Morrell

14. MOTHER'S MAIDEN NAME

Elizabeth Caldwell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

INFORMANT

Address

Washington Sanitarium + Hospital

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

199.2

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.(b)
DUE TO
(c)

Pneumonitis

Carcinoma

INTERVAL BETWEEN
ONSET AND DEATH
2 days

6 mos?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I(a)

Hypertension

19. WAS AUTOPSY PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 1920d. INJURY OCCURRED
While at work Not while at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from _____, 1957, to Nov. 5, 1959, that I last saw the deceased alive on Nov. 5, 1959, and that death occurred at 2:30 PM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type)

Robert A. Hare, M.D.

Robert A. Hare, M.D.

1600 Carroll Ave., Tak. Park, MD 20887

11/19/59

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

Nov. 12-59

22c. NAME OF CEMETERY OR CREMATORI

Lorraine Cemetery

22d. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Ellsworth Armacost

ADDRESS

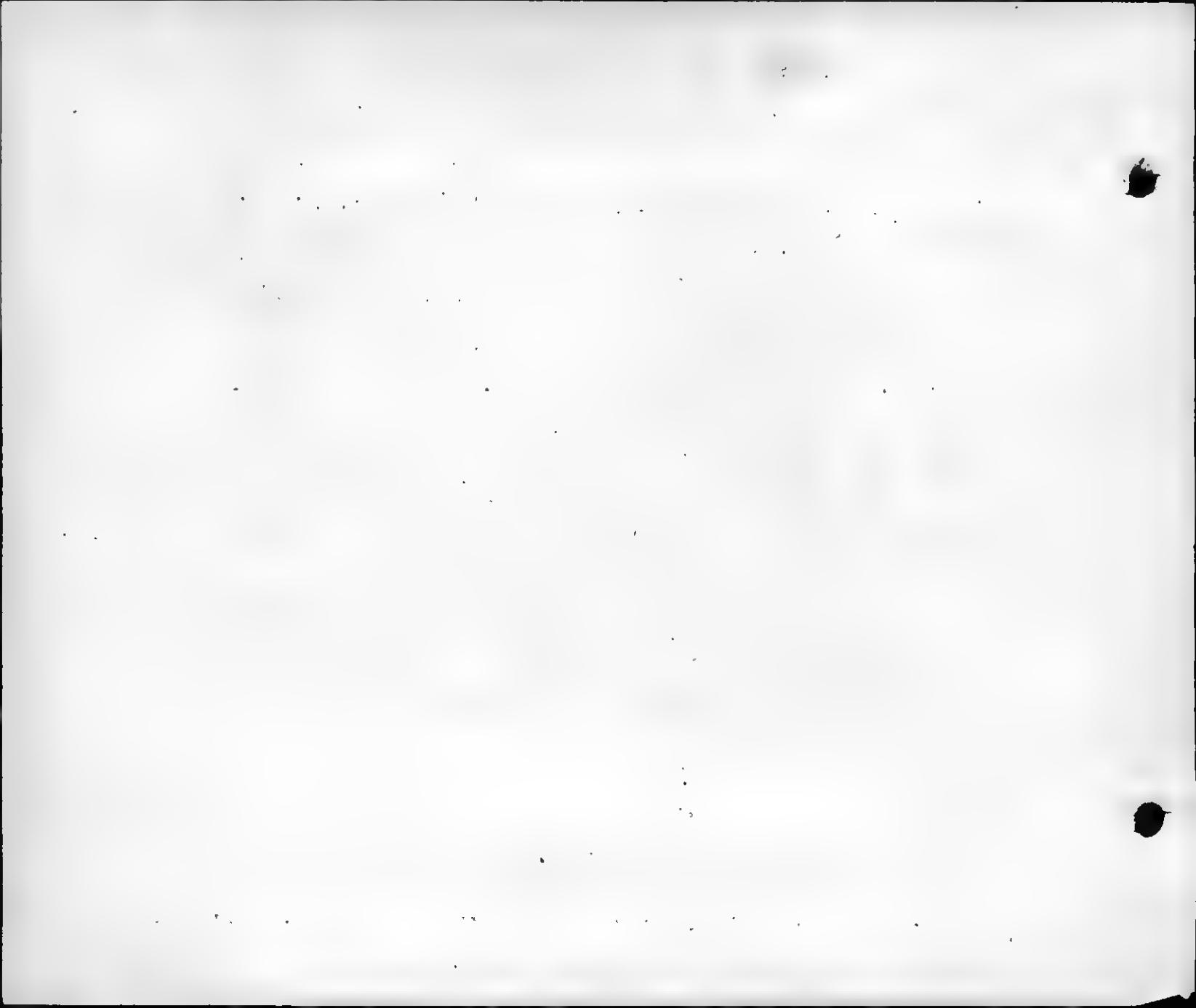
4600 Liberty Hghts.

24a. REC'D BY REGISTRAR

NOV 10 '59

DATE

NOV 10 '59



TO HOSPITAL **INDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this cert. has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

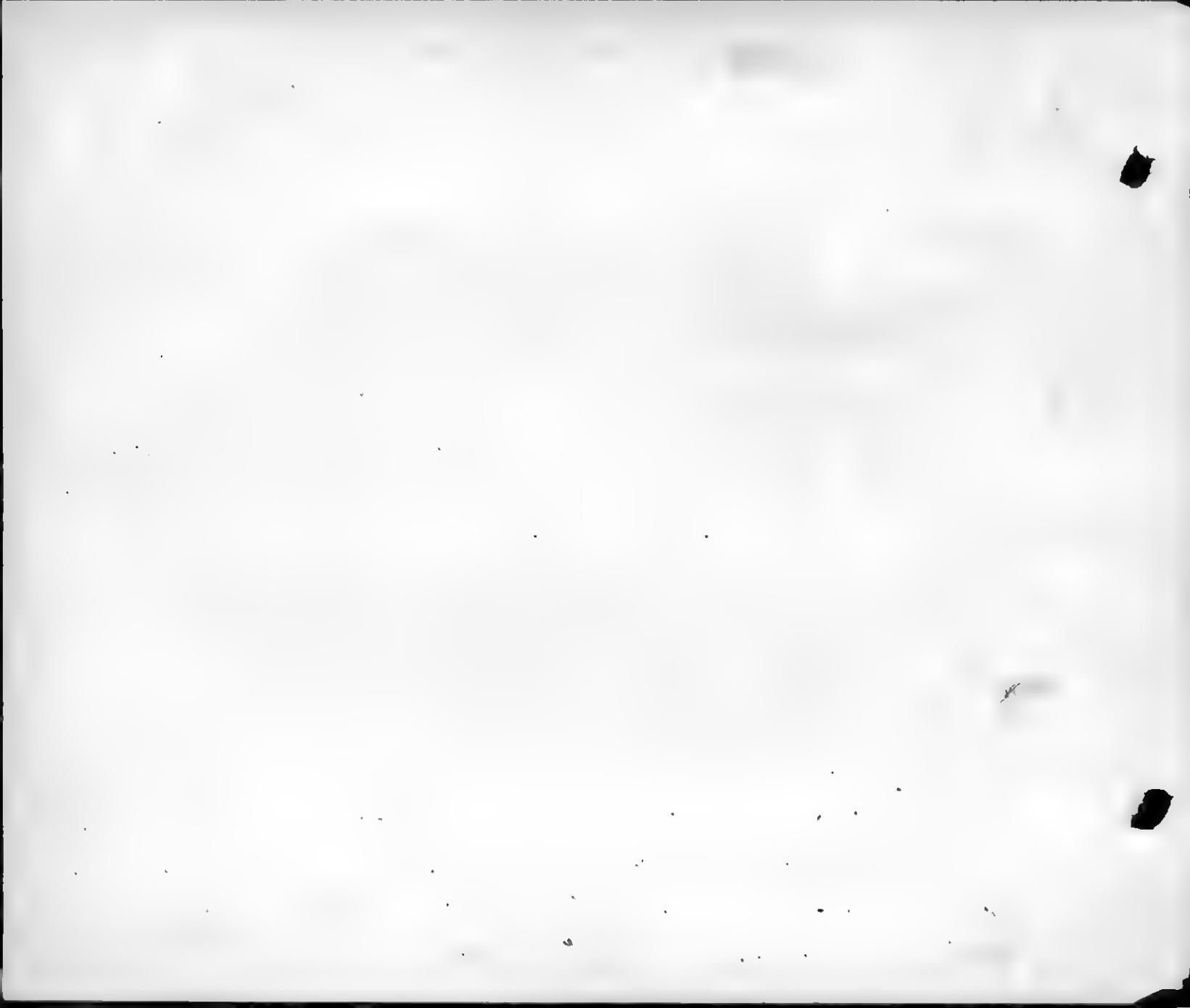
12726

CERTIFICATE OF DEATH

12683

Reg. Dist. No.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN lb 12 days, 7 hrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital | | e. STREET ADDRESS 620 Ritchie Avenue | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First George | Middle D. | Last Copelin |
| 4. DATE OF DEATH | Month November | Day 26 | Year 1959 |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/21/1888 |
| 9. AGE (In years lost birthday) 71 yrs. | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Days 0 | 12. Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME William Copelin | 14. MOTHER'S MAIDEN NAME Nellie Murphy | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. Unknown | INFORMANT Dallas Copelin | Address 808 Ingraham St. NW. Washington, D. C. |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia | | | |
| DUE TO 181.0 | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Papillary Carcinoma of Urinary Bladder | | | |
| DUE TO (c) | | | |
| Unknown | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour o. m. p. m. | Month 19 | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 11/11/1959 , to 11/26/1959 , that I last saw the deceased alive on 11/25/1959 , and that death occurred at 3:00 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Timothy J. Tehan, M.D.</i> | | ADDRESS (Street, city or town state) 8218 Wisconsin Ave., Bethesda, Md. DATE SIGNED 11/26/59 | |
| PHYSICIAN'S NAME (Type) Timothy J. Tehan, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 11-30-59 | 22c. NAME OF CEMETERY OR CREMATORIAL STOKE GROVE | 22d. LOCATION (City, town or county) LAYTONSVILLE, MD. (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Frazer</i> | | ADDRESS Hockville, Md. | |
| | | 24a. REC'D BY REGISTRAR NOV 30 1959 | 24b. REGISTRAR'S SIGNATURE <i>Charles S. Thorne</i> |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12690

Reg. Dist. No.

12727

| | | | | | | | | |
|--|--|--|----------------------|--|---|---|-------------------------------|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN lb DOA | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | | | |
| f. STREET ADDRESS 4201 Dahill Road | | | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) | | First Judith | Middle Ann | Last Cotter | 4. DATE OF DEATH November 18 1959 | Month Day Year | | |
| 5. SEX Female | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH May 24th, 1955 | | |
| 9. AGE (In years last birthday) 4 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child | | 10b. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (State or foreign country) Wash. D.C. | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME James E. Cotter | | | | |
| 14. MOTHER'S MAIDEN NAME Ruth Clark | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | |
| 16. SOCIAL SECURITY NO. 812-54-1234 | | | | 17. INFORMANT James E. Cotter | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Contusions and lacerations from automobile accident 812-54-1234 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Comminuted fracture of skull Immediate DUE TO (c) Automobile accident Immediate | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Struck by car | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour _____ P. m. 11-18 1959 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street | | 20f. (City or town) Wheaton | (County) Montgomery | (State) Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE Frank J. Borschart | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED 11-18-59 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 11/21/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM GATE OF HEAVEN CEMETERY | | 22d. LOCATION (City, town, or county) MONTGOMERY COUNTY, MARYLAND | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WALNUT E. PUMPHREY INC. | | ADDRESS SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR NOV 24 '59 | | 24b. REGISTRAR'S SIGNATURE Collin E. Kline | | |
| VS. A15ME(S) 5M 9/55 | | | | | | | | |

22



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12691

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

| | | | |
|---|--|--|--------|
| 12676 | | | |
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | | c. LENGTH OF STAY IN 1b <i>16 yrs</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>6606 Westmoreland Ave</i> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | |
| f. STREET ADDRESS <i>6606 Westmoreland Ave</i> | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Charles Albert Crawford</i> | | First | Middle |
| 4. DATE OF DEATH <i>Nov 23 1959</i> | | Last | Month |
| 5. SEX <i>Male</i> | | 6. COLOR OR RACE <i>White</i> | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>4-8-1885</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Butcher</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Sophy's store</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>John Crawford</i> | | 14. MOTHER'S MAIDEN NAME <i>not available</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>Alice Crawford (wife)</i> | | Address <i>111-2</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i> | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> | | | |
| 4.20.1 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i> | | | |
| DUE TO <i>(c)</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>History of previous heart disease</i> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <i>None</i> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i> | | 20f. (City or town) (County) (State) <i>None</i> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i> | | DATE SIGNED <i>11-23-59</i> | |
| EXAMINER'S NAME (Type) <i>Frank J. Broschart</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i> | | 22b. DATE THEREOF <i>Nov 25, 1959</i> | |
| 22c. NAME OF CEMETERY OR CREMATORIAL <i>George Washington Cemetery</i> | | 22d. LOCATION (City, town, or county) <i>District George Co. Maryland</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>G. Arthur Waters, 254 Carroll, U. N. C.</i> | | ADDRESS | |
| 24a. REC'D BY REGISTRAR <i>Arthur S. Kline</i> | | 24b. REGISTRAR'S SIGNATURE | |
| DATE <i>NOV 27 '59</i> | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

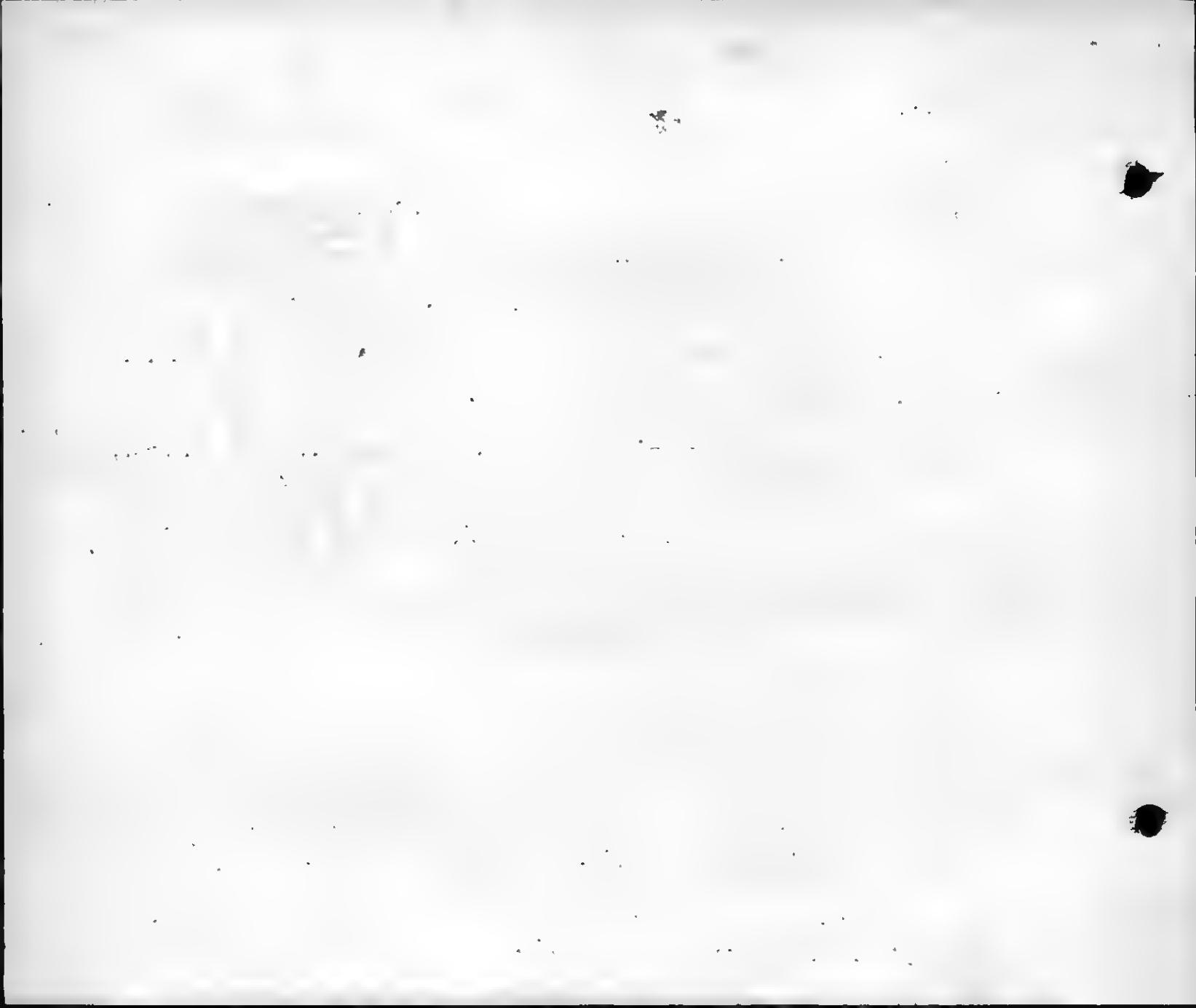
12728

CERTIFICATE OF DEATH

Reg. Dist. No.

12692

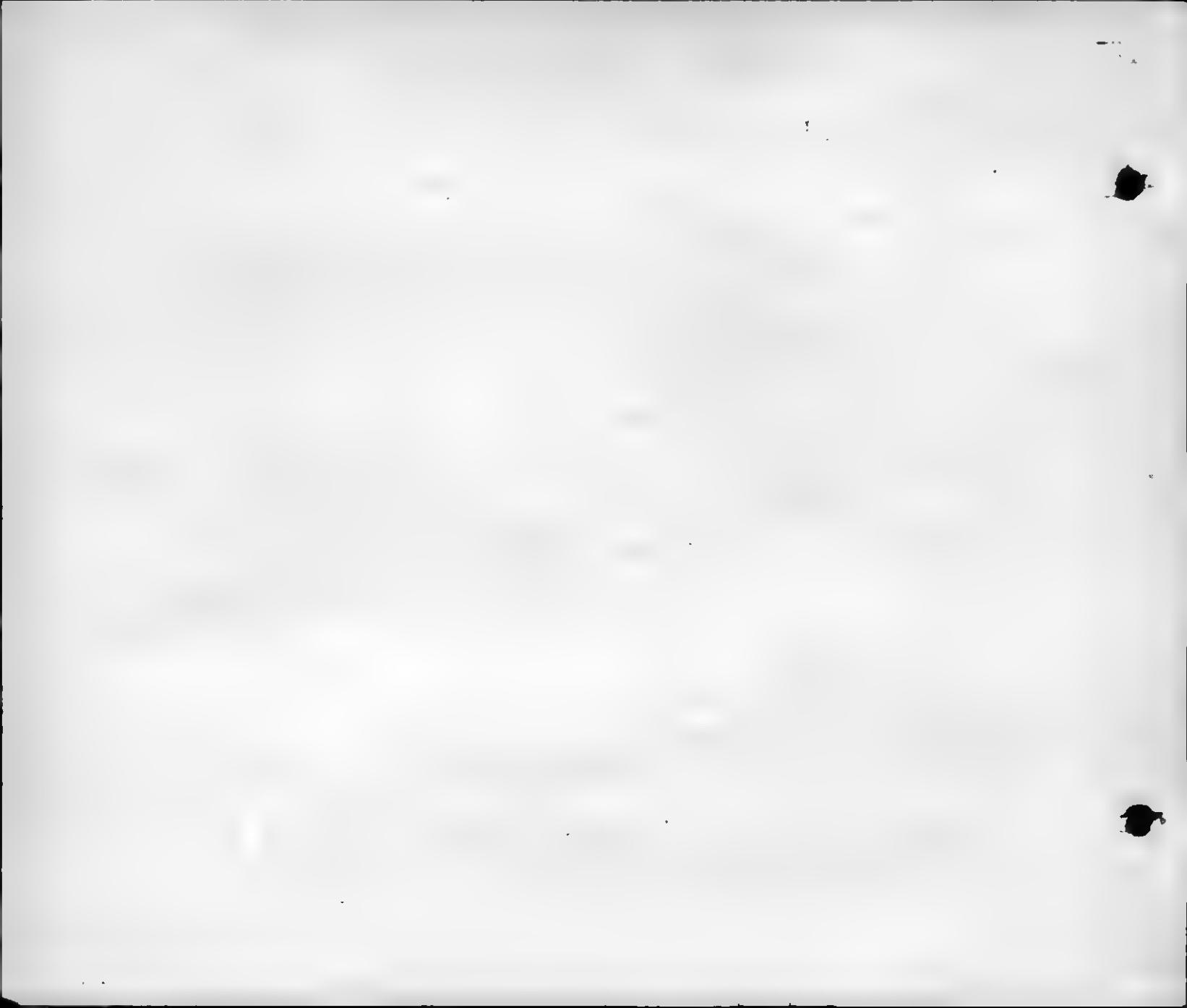
| | | | | | | | | |
|---|---|--|--|--|--|---|--|-------------------------|
| 1 PLACE OF DEATH a. COUNTY MONTGOMERY | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE PENNSYLVANIA | | b. COUNTY PHILADELPHIA | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | c. LENGTH OF STAY IN 1b 6 weeks | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PHILADELPHIA | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 13,306 GEORGIA AVENUE | | d. STREET ADDRESS 2719 W. LEHIGH AVENUE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) CHARLES H. CRAWFORD, SR. | | First | Middle | Last | 4. DATE OF DEATH NOVEMBER 13 | Month | Day | Year 19 59 |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 5, 1880 | 9. AGE (In years last birthday) 79 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. Hours 0 | IF UNDER 24 HRS. Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LINOTYPE MACHINIST | | 10b. KIND OF BUSINESS OR INDUSTRY NEWSPAPER | | 11. BIRTHPLACE (State or foreign country) PENNSYLVANIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME CHARLES W. CRAWFORD | | 14. MOTHER'S MAIDEN NAME LOUISE RHODES | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 164-05-7936 | | INFORMANT CHAS. H. CRAWFORD, JR., 13,306 Ga. Ave., Silver | | Address Spring, Md. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b) 153.9 | | DUE TO (b) | | INTERVAL BETWEEN ONSET AND DEATH Metastatic Cancer of Liver 6 months | | | | |
| Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c) | | DUE TO (c) | | Cancer of Gastrointestinal Tract 1 year | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Arteriosclerosis | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state) | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month 19 | Day | Year | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) Philadelphia, Penn. | (County) Philadelphia, Penn. | (State) Penn. |
| 21. I certify that I attended the deceased from 10/9/59 to 11/13/59 , that I last saw the deceased alive on 11/13/59 , and that death occurred at 11:5 PM , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) JOHN J. CURRY, M.D., 10620 Georgia Ave., Silver Spring, Md. | | | | | | |
| ACTUAL SIGNATURE JOHN J. CURRY, M.D. | | DATE SIGNED 11/13/59 | | | | | | |
| PHYSICIAN'S NAME (Type) JOHN J. CURRY, M.D. | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF NOV. 17, 1959 | 22c. NAME OF CEMETERY OR CREMATORY HILLSIDE CEMETERY | | 22d. LOCATION (City, town, or county) PHILADELPHIA, PENNA. | | (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warren E. Pumphrey, Inc. | | ADDRESS Silver Spring, Md. | | 24a. REC'D BY REGISTRAR NOV 16 59 | 24b. REGISTRAR'S SIGNATURE John J. Curry | | | |
| Raymond C. Zajka | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by general direction, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12729 CERTIFICATE OF DEATH | | | | | | | | | | | | Reg. Dist. No. 12693 |
|--|--|--|--|--|--|--|--|---|---|---------------------------------|------------------|---|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE VIRGINIA b. COUNTY | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLESVILLE | | | c. LENGTH OF STAY IN 1b 3 YEARS | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FALLS CHURCH | | | d. STREET ADDRESS SPRING DRIVE, 208 SLEEPY HOLLOW, | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARILEA REST HOME | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) SUE | | | First R. CRICHLow Middle | | | 4. DATE OF DEATH Nov. 11 1959 | | | Month Day Year | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE CAUCASIAN | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11-22-1874 | | 9. AGE (In years last birthday) 84 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | 10b. KIND OF BUSINESS OR INDUSTRY — | | | 11. BIRTHPLACE (State or foreign country) TENNESSEE | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME BEN RANSOM | | | 14. MOTHER'S MAIDEN NAME SUE SIMS | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | 16. SOCIAL SECURITY NO. | | | 17. INFORMANT Robert W. CRICHLow, 208 SPRING DR, FALLS CHURCH, Address | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Acute myocardial Di. | | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs | | | | | | |
| | | | (b) Chronic myocardial Di. DUE TO | | | | | | | | | |
| | | | (c) Generalized arteriosclerosis DUE TO | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Acute cerebral infarction | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) 1817 Fairview Rd. | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>Nov. 14, 1959</u> , to <u>Nov. 14, 1959</u> , that I last saw the deceased alive on <u>Nov. 14, 1959</u> , and that death occurred at <u>1817 Fairview Rd.</u> M. from the causes and on the date stated above. | | | | | | | | | | | | ADDRESS (Street, city or town, state) <u>Belvoir Spring, Md.</u> DATE SIGNED <u>Nov. 14, 1959</u> |
| ACTUAL SIGNATURE <u>J. H. D. Rogers</u> M.D. | | PHYSICIAN'S NAME (Type) JOHN S. ROGERS | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL Nov. 14, 1959 | | | 22b. DATE THEREOF Nov. 14, 1959 | | | 22c. NAME OF CEMETERY OR CREMATORIUM EVERGREEN CEMETORY | | | 22d. LOCATION (City, town, or county) 1817 FAIRVIEW RD., NASHVILLE, TENN. | | | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Ricciardi Funeral Home</u> | | | ADDRESS <u>816 H St. N.E. Wash. D.C.</u> | | | 24a. REC'D BY REGISTRAR NOV 13 '59 | | | 24b. REGISTRAR'S SIGNATURE <u>C. L. & K. K. K.</u> | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

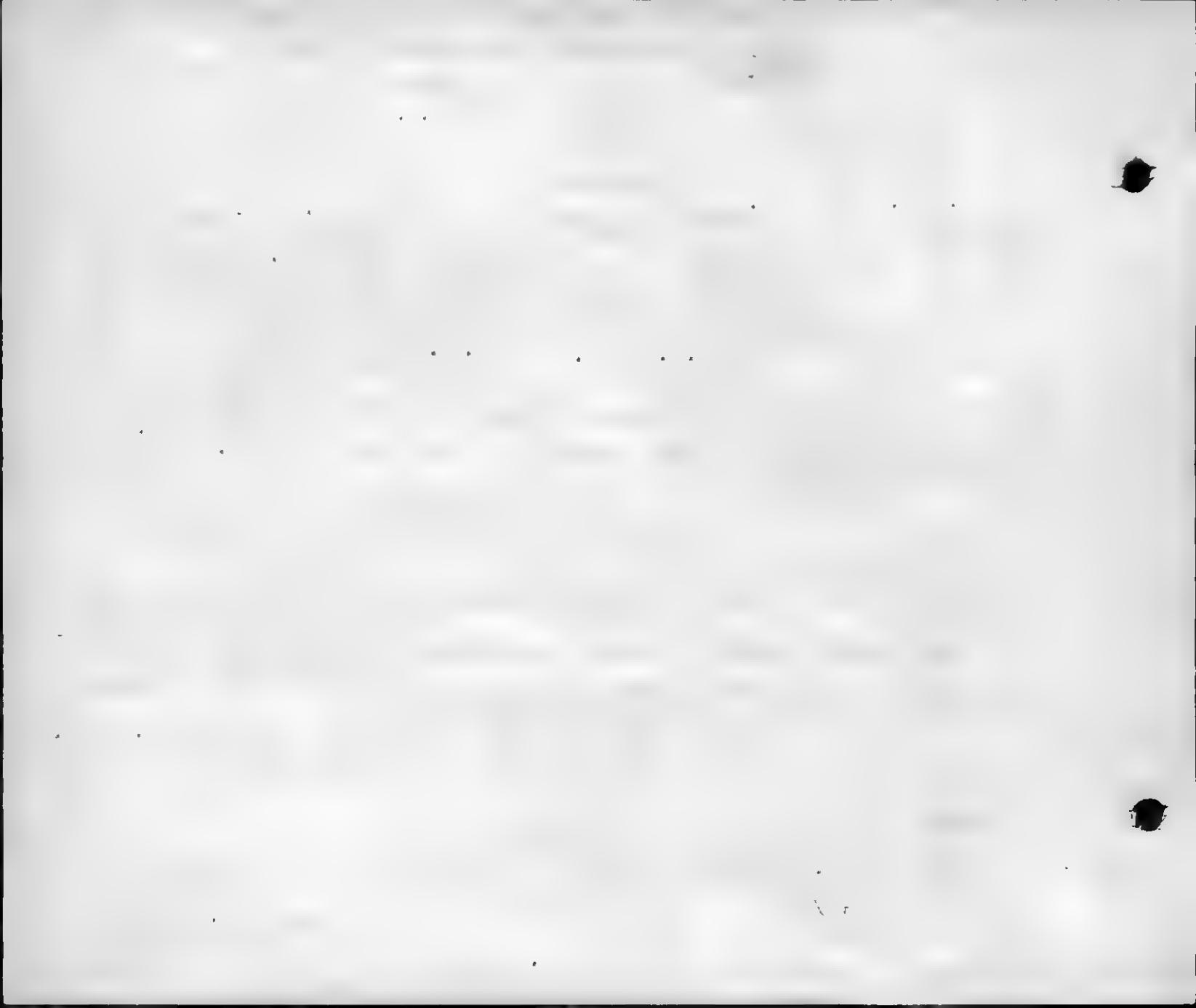
13830

Reg. Dist. No.

12730

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

| | | | | | | | | | | |
|---|-------------------------|--|--|---|--|---|---------------------------------------|---|-----------|--------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] Chevy Chase | | c. LENGTH OF STAY IN IB DOA | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) d. STATE D.C. | | b. COUNTY | | |
| | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | | | |
| | | | | | | d. STREET ADDRESS 1342 Ingerham St., N.W. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | | First Leslie | Middle A. | Cuffee | | Last | 4. DATE OF DEATH Nov. 30, 1969 | Month Nov. | Day 30 | Year 1969 |
| 5. SEX male | 6. COLOR OR RACE col | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/9/16 | | 9. AGE (In years last birthday) 44 yrs. | 10. IF UNDER 1YEAR Months Years | 11. IF UNDER 24 HRS. Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Truck Driver | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. | | 11. BIRTHPLACE (State or foreign country) N. Y. | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 13. FATHER'S NAME William Cuffee | | 14. MOTHER'S MAIDEN NAME Mildred Unknown | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes | | 16. SOCIAL SECURITY NO. B-12-42-1529 | | 17. INFORMANT Harold Cole | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage & Laceration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Crushed Skull (b) Auto accident DUE TO (c) Auto accident PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Driver of mail truck which collided with another vehicle | | | | |
| | | | | | | INTERVAL BETWEEN ONSET AND DEATH Sudden | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of mail truck which collided with another vehicle | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 11/30 p.m. 4 19 59 | | 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street | | 20f. (City or town) Chevy Chase (County) Montg. (State) Md. | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i> | | EXAMINER'S NAME (Type) Frank J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 11/30/59 | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 12/1/59 | | 22c. NAME OF CEMETERY OR CREMATORIAL Buffalo Crematory | | 22d. LOCATION (City, town, or county) Md. (State) | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Monroe Woodford</i> | | ADDRESS 14672 1/2 West Hwy | | 24a. REC'D BY REGISTRAR DEC 9 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | | | | |



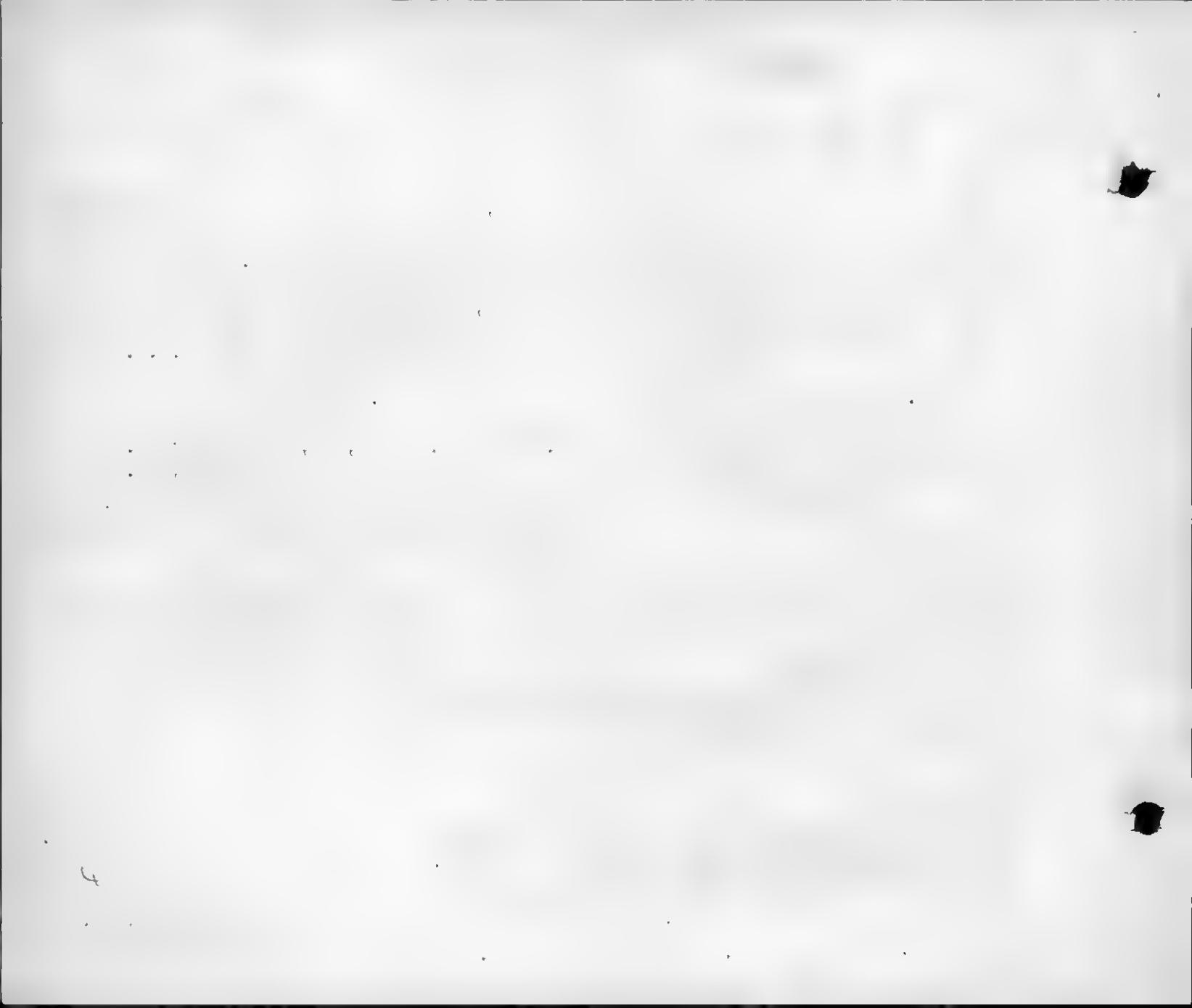
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12694

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | | |
|--|----------------------------------|---|---|--|---|--|--|---|--|-------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | MARYLAND | | 2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE MARYLAND | | b. COUNTY MONTGOMERY | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG | | c. LENGTH OF STAY IN lb 9 months | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION REST HAVEN NURSING HOME | | d. STREET ADDRESS 11,818 HUGGINS DRIVE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) MARY | | First MARY | Middle ALICE | Last CUMMINGS | 4. DATE OF DEATH NOV. 24 1959 | Month NOV. | Day 24 | Year 1959 | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED | 8. DATE OF BIRTH May 7, 1875 | 9. AGE (In years from last birthday) 84 yrs | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Days 0 | 12. IF UNDER 24 HRS Hours 0 | 13. MIN | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY Own home | | 11. BIRTHPLACE (State or foreign country) PENNSYLVANIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 13. FATHER'S NAME JOHN F. MOORE | | | 14. MOTHER'S MAIDEN NAME KATHERINE E. TIPPETT | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT Mr. Joseph B. Moore, 11,818 Huggins Dr. | | Address Silver Spring, MD. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CITRONIC Renal Failure With GRENIA 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) CEREBRAL THROMBOSIS DUE TO (c) HYPERTENSIVE ARTERIOSCLEROTIC Heart Disease 20 yrs | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 years | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) PARTIAL LARGE BOWEL OBSTRUCTION | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) PRINCE GEORGES COUNTY, MD. | | (County) PRINCE GEORGES COUNTY, MD. | (State) MD. | |
| 21. I certify that I attended the deceased from August 10, 1959 to Nov. 24, 1959 , that I last saw the deceased alive on Nov. 23, 1959 , and that death occurred at 2:30 AM , from the causes and on the date stated above. | | | | | | | | | | |
| ACTUAL SIGNATURE Jordon S. Rosenberger M.D. 26 North Summit Ave Nov. 24, 1959 PHYSICIAN'S NAME (Type) JORDON S. ROSENBERGER | | | | | | | | | ADDRESS (Street, city or town, state) 9 Brothers Bldg., Maryland | DATE SIGNED |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 11/28/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM FT. LINCOLN CEMETERY | | 22d. LOCATION (City, town, or county) PRINCE GEORGES COUNTY, MD. | | (State) MD. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. HUMPHREY, INC. | | ADDRESS SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR DATE NOV 25 '59 | | 24b. REGISTRAR'S SIGNATURE Caroline S. Krause | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12732

CERTIFICATE OF DEATH

12695

Reg. Dist. No.

| | | | |
|---|-------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING</i> | | c. LENGTH OF STAY IN 1b <i>10 yrs.</i> | |
| d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING</i> | | e. STREET ADDRESS <i>821-University Blvd. East</i> | |
| 3. NAME OF DECEASED (Type or print) <i>ETTA FRANCES CURTIS</i> | | 4. DATE OF DEATH Month <i>11</i> Day <i>25</i> Year <i>1954</i> | 5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 5. SEX <i>FEMALE</i> | 6. COLOR OR RACE <i>WHITE</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>8-20-1866</i> |
| 9. AGE (In years last birthday) <i>93 yrs</i> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i> | 11. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i> |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>MARTIN GROFF</i> | 14. MOTHER'S MAIDEN NAME <i>Elvira ?</i> |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>NONE</i> | 17. INFORMANT Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Senility</i> DUE TO <i>450.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Mycobacterial tuberculosis</i> DUE TO (c) | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour o. m. p. m. | Month, Day, Year 19 | 20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>April</i> , 19 <i>48</i> , to <i>Nov 24</i> , 19 <i>54</i> , that I last saw the deceased alive on <i>Nov 24</i> , 19 <i>54</i> , and that death occurred at <i>8:30 AM</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE <i>Frances E. Curtis</i> M.D. 217 University Blvd. E. 11-25-54 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 22b. DATE THEREOF <i>11/28/59</i> | 22c. NAME OF CEMETERY OR CREMATORIUM <i>MT. OLIVET</i> |
| 22d. LOCATION (City, town, or county) <i>WASH. D.C.</i> | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Timothy Henton</i> | | 24a. ADDRESS <i>3831-GA AVENUE</i> | 24b. REC'D BY REGISTRAR DATE <i>DEC 7 '59</i> |
| | | 24b. REGISTRAR'S SIGNATURE <i>John S. Krause</i> | |

TO HOSPITALS: The law requires that the death certificate be executed within 24 hours after death; page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

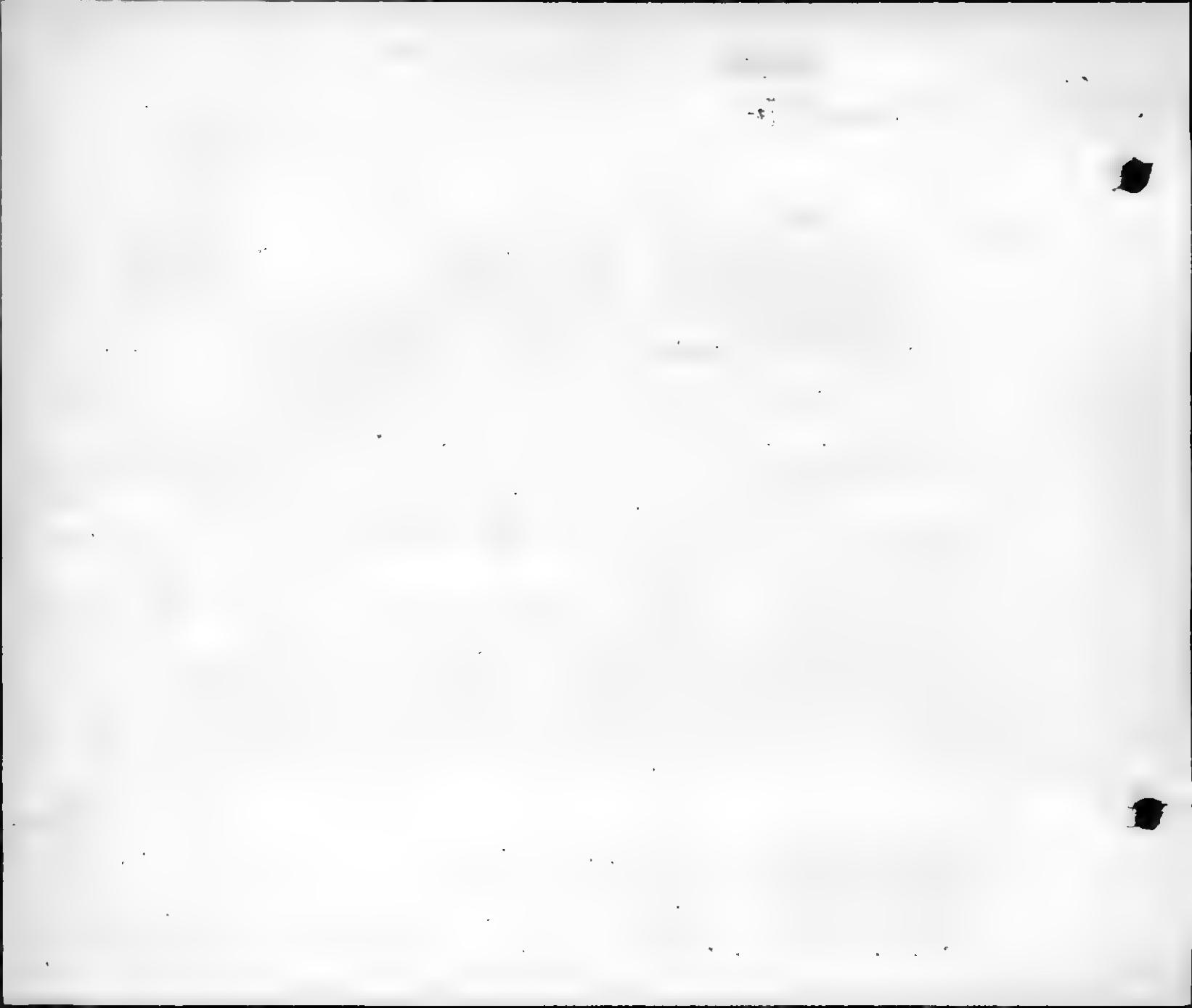
12696

12733

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|-----------------------------------|---|---------------------------------------|--|--|--|---------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase | | d. STREET ADDRESS 5609 Grove Street | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First JOHN | Middle Middle | Last DAVIES | 4. DATE OF DEATH | Month November | Day 17 | Year 1959 |
| S. SEX Male | 16. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-24-1870 | 9. AGE (In years last birthday) 89 yrs | 10. IF UNDER 1 YEAR 0 months 29 days | 11. IF UNDER 24 HRS Hours 23 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Comptroller | | 10b. KIND OF BUSINESS OR INDUSTRY Woodward & Loth, Washington, D. C. | | 11. BIRTHPLACE (State or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William Davies | | 14. MOTHER'S MAIDEN NAME Elizabeth Kirkwood | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. - - - - - | | INFORMANT Robert Davies-Brother-Item #2 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Congestive Heart Failure INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Coronary Atherosclerosis ONSET AND DEATH DUE TO 10 hours (c) 10 years | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Aug , 19 50 , to Nov 17 , 19 59 , that I last saw the deceased alive on Nov 17 , 19 59 , and that death occurred at 6 P.M. , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) 1716 Rhode Island Ave., N.W., Wash. D.C. DATE SIGNED Nov 17 1959 | | | | | | | |
| ACTUAL SIGNATURE John O. Schreiber M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) John O. Schreiber 1716 Rhode Island Ave., N.W., Wash. D.C. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11-20-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Congressional Cem. | | 22d. LOCATION (City, town, or county) (State) Washington, D. C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland ADDRESS | | | | | | | |
| | | | | 24a. REC'D BY REGISTRAR DATE NOV 20 1959 | | 24b. REGISTRAR'S SIGNATURE C. W. & H. H. | |



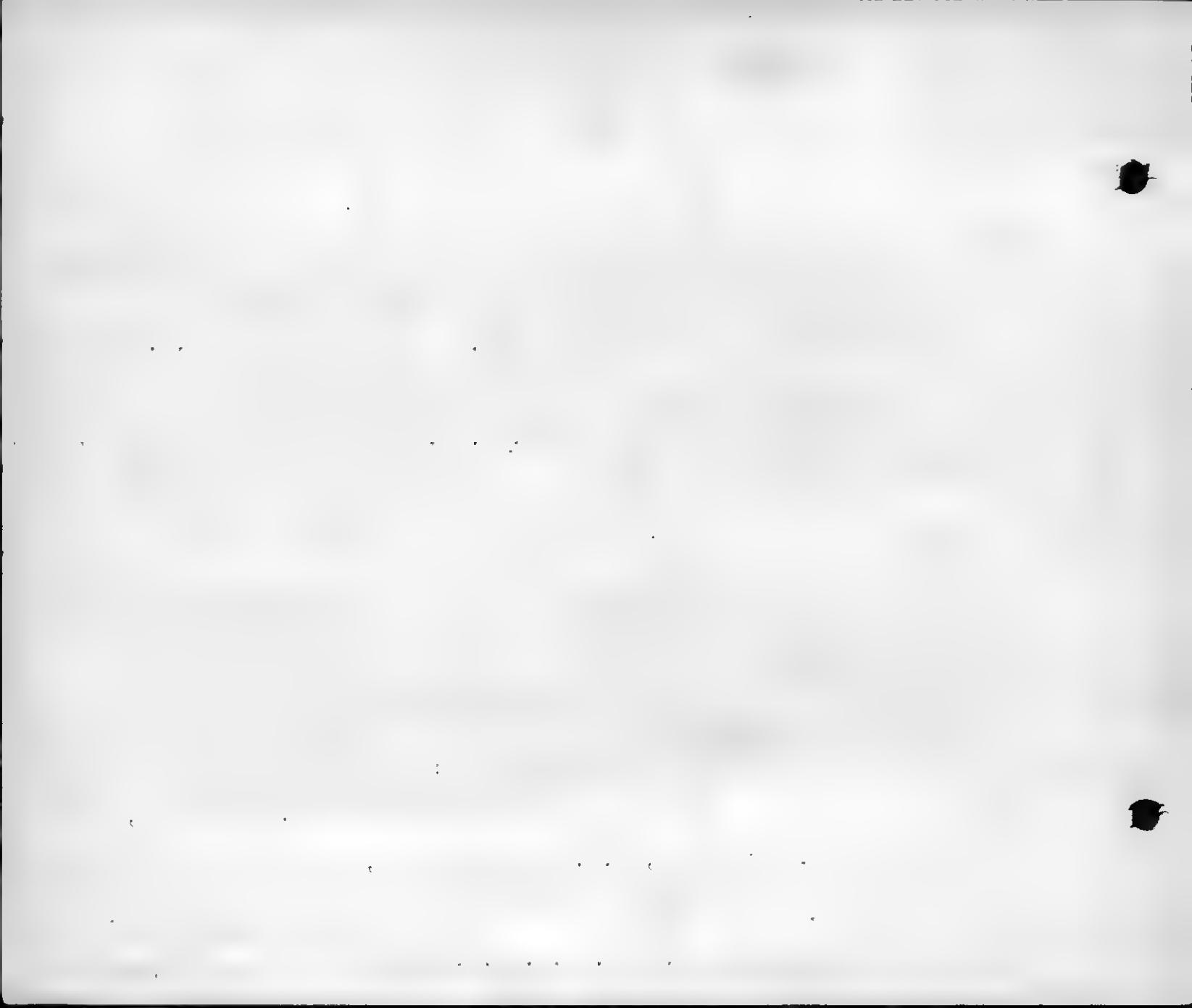
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12698

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | |
|---|-------------------------------|---|---------------------------------|---|---|--|-----------------------------------|---------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland | | b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Le Beau Gardens Nursing Home | | | | d. STREET ADDRESS 7111 13th Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) Montgomery | | First | Middle | Lost | 4. DATE OF DEATH Davis | Month November | Day 10 | Year 19 59 |
| 5. SEX Male | 6. COLOR OR RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 10 1874 | | 9. AGE (In years lost birthday) 85 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Va. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Montillion Davis | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Herndon | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. E. E. Santemma | | Address 500 Front St L.I. N. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | Acute Uremia | | | | INTERVAL BETWEEN ONSET AND DEATH One Week | | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. | | Acute Renal Shutdown | | | | Two Days | | |
| DUE TO (b) (c) Gastrointestinal Hemorrhage | | | | | | Four Days | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Stafford County | | (State) |
| NOV 8 1959 | | | | | | | | |
| 21. I certify that I attended the deceased from <u>Nov 9 1959</u> , to <u>Nov 10 1959</u> , that I last saw the deceased alive on <u>Nov 9 1959</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above. | | | | | | | | |
| ADDRESS (Street, city or town, state) <u>10609 Concord St.</u> DATE SIGNED <u>Nov 10, 1959</u> | | | | | | | | |
| ACTUAL SIGNATURE <u>Robert T. Thibadeau, M.D.</u> | | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>Robert T. Thibadeau, M.D.</u> Kensington Maryland | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Nov. 12 1959</u> | | 22c. NAME OF CEMETERY OR CREMATORIY <u>Rock Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) <u>Stafford County Va.</u> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Deal Funeral Home 4812 Ga. Ave. N.W. D.C.</u> REC'D BY REGISTRAR <u>DATE NOV 12 '59</u> REGISTRAR'S SIGNATURE <u>C. Chay S. Thomas</u> | | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

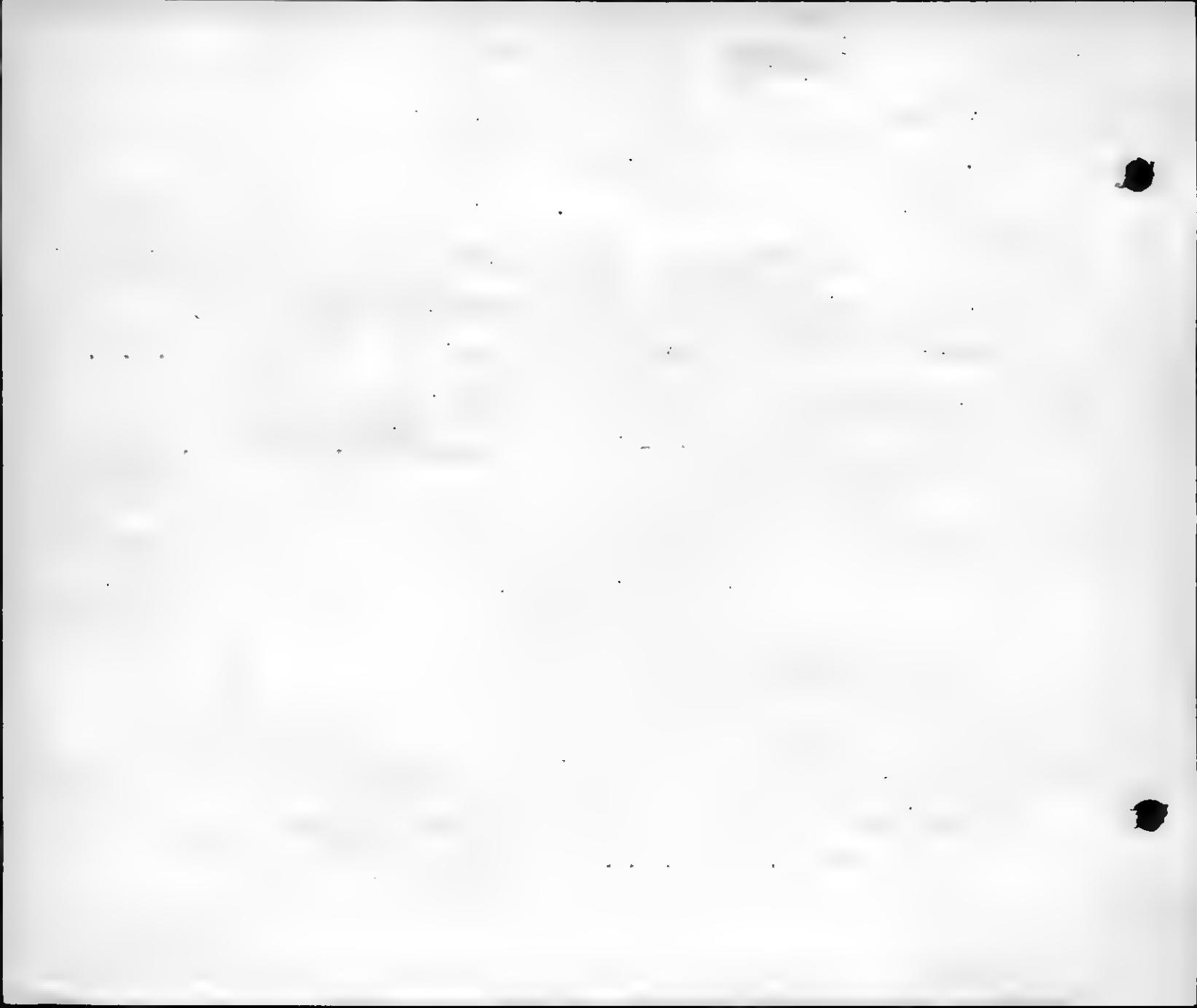
12693

12735

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--------------------------|---|---|---|--------------------------------|---|--------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York | | b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 114 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belle Harbor | | d. STREET ADDRESS 147 Beach, 136th Street | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Harry | Middle (None) | Last Deutsch | 4. DATE OF DEATH | Month November | Day 11 | Year 1959 |
| 5. SEX Male | 6 COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 19, 1911 | 9. AGE (in years last birthday) 48 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS Days 0 | Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist | | 10b. KIND OF BUSINESS OR INDUSTRY Dental | | 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Morris Deutsch | | | 14. MOTHER'S MAIDEN NAME Naomi Yasgour | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 976-32-3034 | | INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 134.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Endocarditis DUE TO (c) Candida Guilliermondi INTERVAL BETWEEN ONSET AND DEATH Immediate 6 months 6 months | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 20, 1959, to November 11, 1959, that I last saw the deceased alive on November 11, 1959, and that death occurred at 6:10 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Howard M. Kravetz, M.D. 11/11/59 | | | | | | | |
| ACTUAL SIGNATURE Howard M. Kravetz, M.D. | | M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland | | | | | |
| PHYSICIAN'S NAME (Type) | | 11/11/59 | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 11-13-59 | | 22c. NAME OF CEMETERY OR CREA WELLWOOD CEMETERY | | 22d. LOCATION (City, town, or county) FINELAWN, L.I., N.Y. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY & SONS | | ADDRESS 3501-14th St. N.W. | | 24a. REC'D BY REGISTRAR DATE NOV 13 '59 | | 24b. REGISTRAR'S SIGNATURE Howard M. Kravetz | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12700

12736

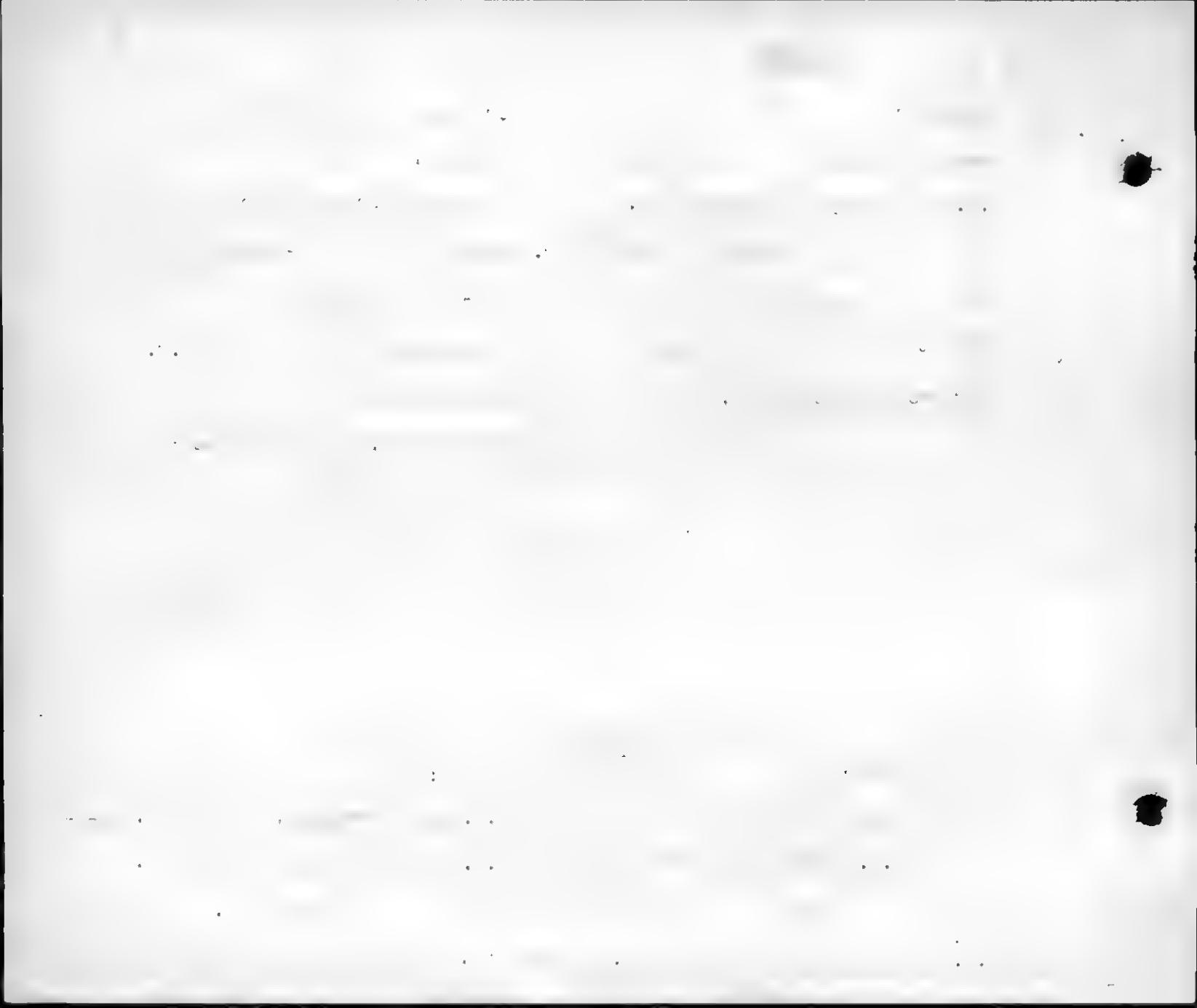
CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

| | | | | | | | | |
|---|--|---|---|--|--|---|---|---------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Res dence before admission) a. STATE Virginia | | b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN lb 1 day | | c. CITY OR TOWN (If outside corporate limits, write RURAL and g've nearest town) Arlington | | d. STREET ADDRESS 705 North Harrison Street | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md. | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) George Clayton Jr. DIXON | | First George | Middle Clayton Jr. | Last DIXON | 4. DATE OF DEATH November 8 1959 | Month November | Day 8 | Year 1959 |
| 5. SEX Male | | 6 COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | B. DATE OF BIRTH 10-30-42 | 9. AGE (In years last birthday) 17 yrs | IF UNDER 1 YEAR Months 17 | IF UNDER 24 HRS. Days Hours Min. | |
| 10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Louisiana | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | |
| 13. FATHER'S NAME George Clayton DIXON SR. | | | | 14. MOTHER'S MAIDEN NAME Marion RAMSEY | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | INFORMANT (Father) George C. Dixon | | Address Same as #2 | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure INTERVAL BETWEEN ONSET AND DEATH 1441 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis DUE TO (c) Muscular Dystrophy | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Muscular Dystrophy | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from 7 November 1959 to 8 November 1959 that I last saw the deceased alive on 8 November 1959 and that death occurred at 3:25 PM , from the causes and on the date stated above. | | | | | | | | |
| ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. | | | | | | | | |
| DATE SIGNED 11-9-59 | | | | | | | | |
| ACTUAL SIGNATURE Kenneth C. ... | | M.D. | | | | | | |
| PHYSICIAN'S NAME (Type) K. M. MOSER LT MC USN | | U.S. Naval Hospital, Bethesda Md. | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11-13-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Arlington National | | 22d. LOCATION (City, town, or county) Arlington Va. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey | | ADDRESS 7557 Wisconsin Ave. Bethesda Md. | | 24a. REC'D BY REGISTRAR NOV 16 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur & Traas | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

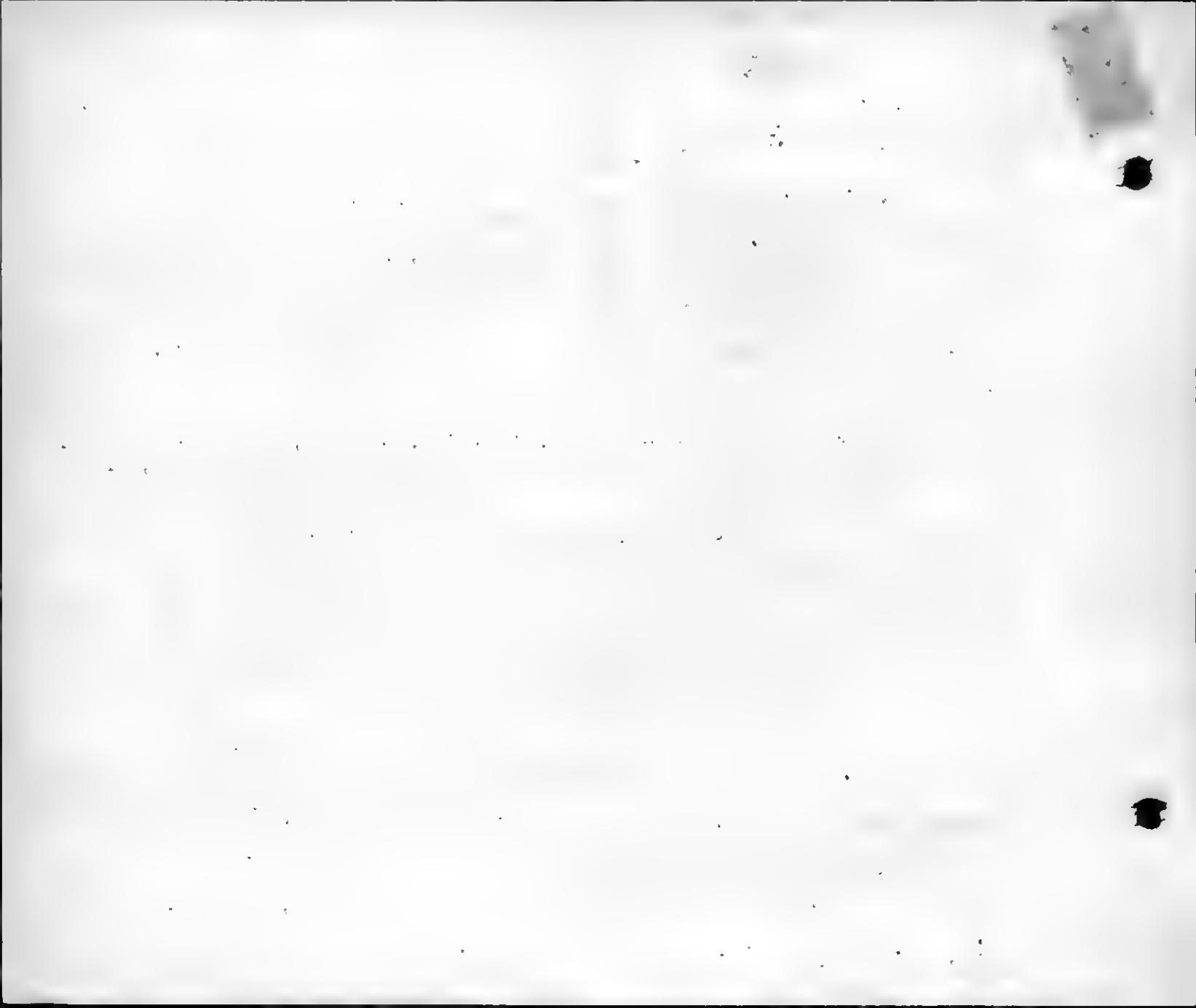
12701

12737

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | 2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA | | c. LENGTH OF STAY IN lb 1 hr. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HAXX SUBURBAN HOSPITAL | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | |
| 3. NAME OF DECEASED (Type or print) | | First Michael R | Middle |
| 4. DATE OF DEATH Last Dobridge SR | | Month Nov. 9 | Day Year 1959 |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/17/96 |
| 9. AGE (In years last birthday) 63 yrs | | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS. Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Embroidery | | 10b. KIND OF BUSINESS OR INDUSTRY Garment Industry | |
| 10c. BIRTHPLACE (State or foreign country) New Jersey | | 11. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME MARK DOBRIDGE | | 14. MOTHER'S MAIDEN NAME unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes | | 16. SOCIAL SECURITY NO. 152-09-5445 | INFORMANT Dr. Michael R. Dobridge, 1421 Crestridge Dr., Silver Spring, MD |
| 17. ADDRESS Silver Spring, MD | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last } (b) Arteriosclerotic Heart Disease 1-2 yrs. DUE TO (c) | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Dec 1959 to Nov 9 1959, and that death occurred at 6A M, from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) George Sharpe, M.D. 10511 Semin. Ave, Kensington, Md. DATE SIGNED 11/9/59 | |
| ACTUAL SIGNATURE George Sharpe | | PHYSICIAN'S NAME (Type) George Sharpe | |
| 22a. BURIAL, CREMATON, REMOVAL (Specify) TRANS & BURIAL | | 22b. DATE THEREOF 11/10/59 | 22c. NAME OF CEMETERY OR CREMATORIUM MADONNA CEMETERY |
| 22d. LOCATION (City, town, or county) FORT LEE, NEW JERSEY | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. | | 24a. REC'D BY REGISTRAR DATE NOV 13 '59 | 24b. REGISTRAR'S SIGNATURE C. Lewis & Trans |
| VS A15 (4) 15M 9/58 | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12702

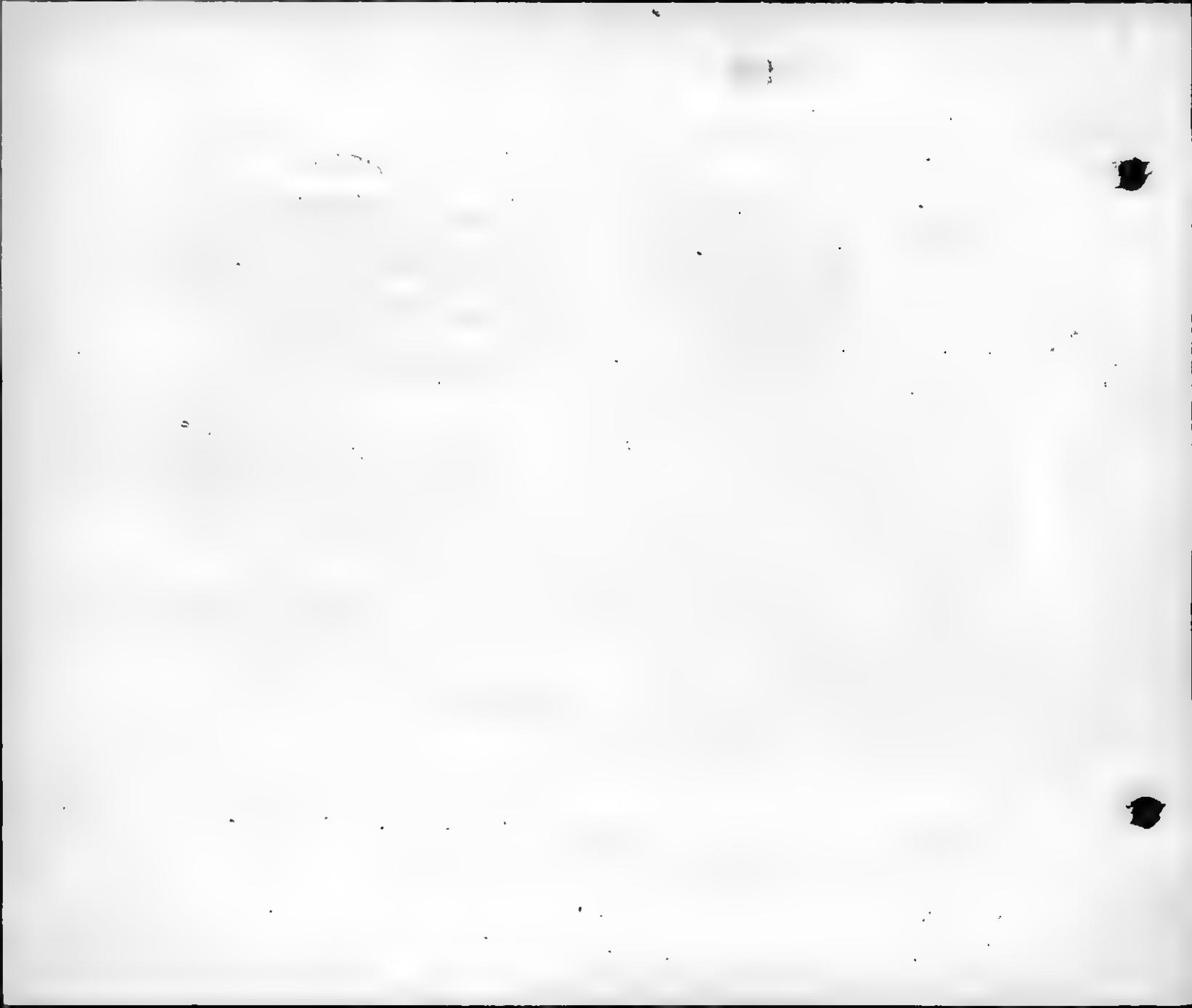
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | |
|--|--|---|---|--|---------------------------------------|---|---|-----------------------------|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VIRGINIA | | b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA | | c. LENGTH OF STAY IN 1b 15 Days 15 1/2 hrs | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLONIAL BEACH | | d. STREET ADDRESS 115 LOCUST AVENUE | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) WALTER C. | | First | Middle | Last | 4. DATE OF DEATH DRURY, SR. | Month | Day | Year | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. DATE OF BIRTH 2-9-1887 | 10. AGE (In years last birthday) 72 yrs | 11. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RESTAURANT OPERATOR | | 10b. KIND OF BUSINESS OR INDUSTRY Restaurant | | 11. BIRTHPLACE (State or foreign country) WEST VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME John Samuel | | 14. MOTHER'S MAIDEN NAME Drury | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 579-01-5589 | | INFORMANT WALTER C. DRURY JR. | | Address 3819 BENTON ST. N.W., WASHINGTON 7, D.C. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | DUE TO 157X | | INTERVAL BETWEEN ONSET AND DEATH 3 weeks | | | | | |
| | | (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | |
| | | (c) | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) M.D. 10110 Georgia Ave., Silver Spring Md | | (County) 11/15/59 | (State) |
| 21. I certify that I attended the deceased from Nov , 19 51 , to Nov 15 , 19 59 , that I last saw the deceased alive on Nov 15 , 19 59 , and that death occurred at 5 1/2 A.M. from the causes and on the date stated above | | ADDRESS (Street, city or town, state) 10110 Georgia Ave., Silver Spring Md | | | | | | | DATE SIGNED 11/15/59 |
| ACTUAL SIGNATURE John Lawrence Avery | | PHYSICIAN'S NAME (Type) M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF Nov. 17, 1959 | | 22c. NAME OF CEMETERY OR CREMATORIUM MT. OLIVET CEMETERY | | 22d. LOCATION (City, town, or county) WASHINGTON, D.C. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE 21. Don. DeSyl 2224-Wis Ave | | ADDRESS R.C. | | 24a. REC'D BY REGISTRAR NOV 20 59 | | 24b. REGISTRAR'S SIGNATURE Charles S. Frank | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12703

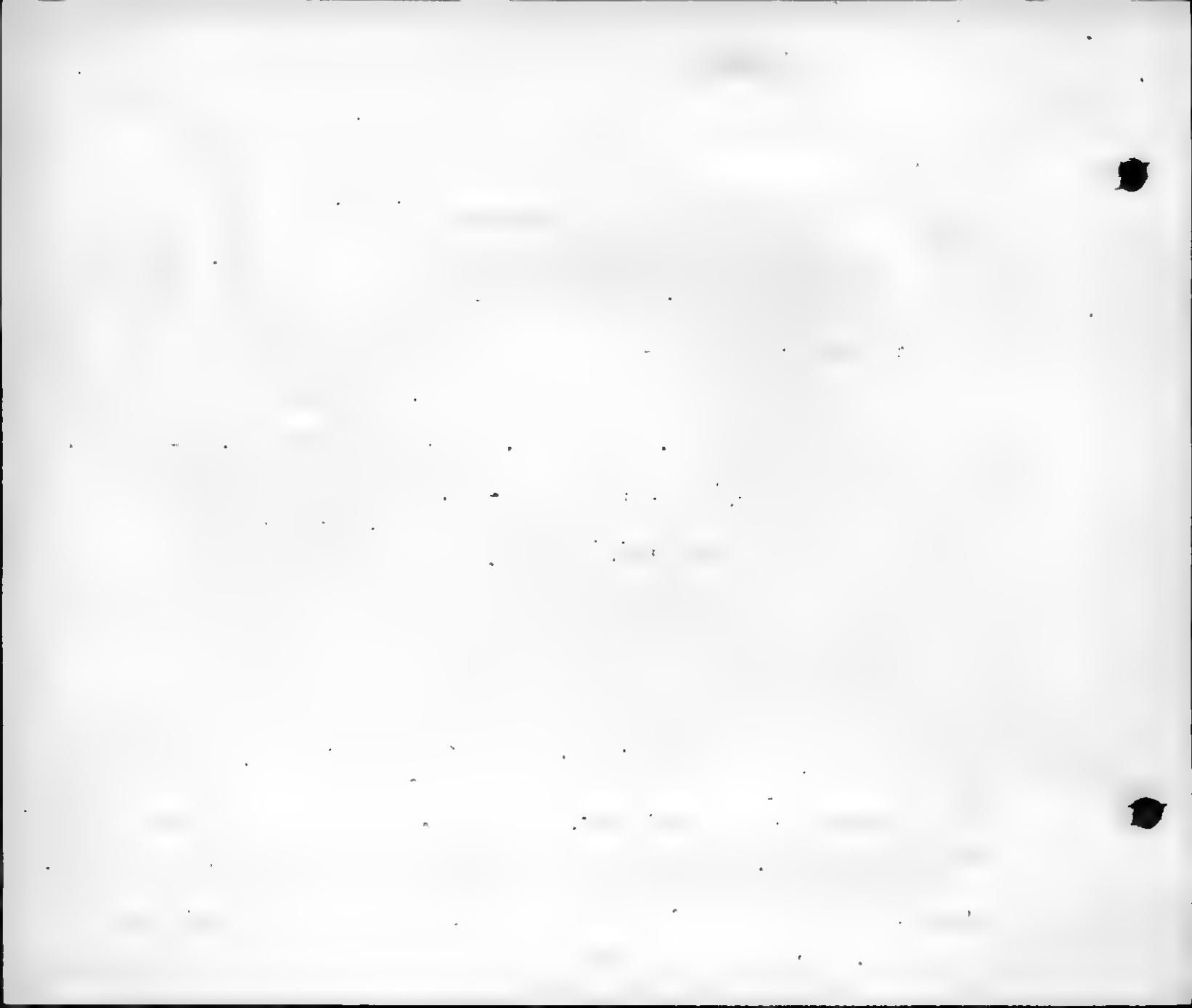
Reg. Dist. No.

CERTIFICATE OF DEATH

12697

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11916 Maple Avenue | | d. STREET ADDRESS 11916 Maple Avenue | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) RICHARD THOMAS DULEY | | First | Middle |
| Last | | 4. DATE OF DEATH Nov. 4 1959 | Month Day Year |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/13/1877 |
| 9. AGE (In years last birthday) 82 yrs. | | 10. IF UNDER 1 YEAR 8 months 21 days | 11. IF UNDER 24 HRS Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? US | | 13. FATHER'S NAME Thomas Duley | |
| 14. MOTHER'S MAIDEN NAME Susie Harris | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | |
| 16. SOCIAL SECURITY NO. 218-14-8622 | | INFORMANT Mrs. Maywood Cross-daughter-same 2d | |
| 17. ADDRESS | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 101-4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) | |
| INTERVAL BETWEEN ONSET AND DEATH | | <i>Squamous Cell carcinoma of Skin of neck with generalized metastases</i> | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct. 18, 1959 to Nov. 4, 1959 that I last saw the deceased alive on Nov. 4, 1959 , and that death occurred at 6:30 PM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Arthur F. Woodward</i> | | ADDRESS (Street, city or town, state) 41 West Wood Lane, Rockville, Md. | |
| PHYSICIAN'S NAME (Type) Arthur F. Woodward | | DATE SIGNED 11/4/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/7/59 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM Potomac Church Cem. | | 22d. LOCATION (City, town, or county) Potomac, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Maryland | |
| 24a. REC'D BY REGISTRAR NOV 6 '59 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12704

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Montgomery | |
| 12739 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN | | c. LENGTH OF STAY IN lb d. STREET ADDRESS 6 Silver Spring 1600 EAST West Hwy | |
| 3. NAME OF DECEASED (Type or print) JULIAN SANFORD Egre | | First JULIAN | Middle SANFORD |
| 3. NAME OF DECEASED (Type or print) JULIAN SANFORD Egre | | Last Egre | 4. DATE OF DEATH Nov. 15 1954 |
| 5. SEX MALE | | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH Feb 18, 1909 | | 9. AGE (In years (last birthday) 50 yrs. | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAWYER | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't. Fed. Trade Comm. | 11. BIRTHPLACE (State or foreign country) WISCONSIN |
| 13. FATHER'S NAME Stephen J. Egre | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No W.W. #2 & Korean | | 16. SOCIAL SECURITY NO. 577-54-4756 | 17. INFORMANT Elinor G. Egre |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion | | INTERVAL BETWEEN ONSET AND DEATH pushed | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | DUE TO | |
| DUE TO | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Frank J. Broschart | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 1:30 P.M. 11-15-54 |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Nov. 18, 1959 | 22c. NAME OF CEMETERY OR CREMATORIUM Arlington National Cemetery | 22d. LOCATION (City, town, or county) (State) Arlington County, Virginia |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc., Silver Spring, Md. | ADDRESS Raymond A. Jiska | 24a. REC'D BY REGISTRAR DATE NOV 18 '59 | 24b. REGISTRAR'S SIGNATURE C. E. G. Kline |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 18-21 Fill

12705

Reg. Dist. No.

12740
1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL
and give nearest town)

Bethesda

c. LENGTH OF STAY IN 1b

2 days, 11 hr.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Dist. of Col. b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Washington

41 X 3

d. STREET ADDRESS

3450 38th Street, N.W.

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First
Eva

Middle

Last
Evans

4. DATE
OF
DEATH

Month November
30

Doy 19
Year 59

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

WIDOWED
DIVORCED

January 12, 1877

9. AGE (In years
last birthday)

82 yrs.

10. IF UNDER 1 YEAR

Months 0
Days 0

11. IF UNDER 24 HRS.

Hours 0
Min. 0

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

No.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Downs

14. MOTHER'S MAIDEN NAME

Ramsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
No.

16. SOCIAL SECURITY NO.

Yes

17. INFORMANT

Ruth E. Perry - 3450 - 38th. St., N.W.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Intra peritoneal hemorrhage

INTERVAL BETWEEN
ONSET AND DEATH

DUE TO

(b) Rupture of liver

3 days

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(c) Fall down stairs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Fell down a flight of stairs

20c. TIME OF INJURY Month, Day, Year
Hour 11
P. m. 27 1959

20d. INJURY OCCURRED
White at work Not white at work

20e. PLACE OF INJURY (Name, firm,
factory, street, office bldg., etc.)

20f. (City, town)
(County)
(State)

Home

Washington

DC

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

Frank J. Broschart

DATE SIGNED

EXAMINER'S
NAME (Type)

FRANK J. Broschart

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

11-30-59

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (Cty, town, or county)
(Street)

Burial

12/3/59

Rock Creek Cemetery

Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

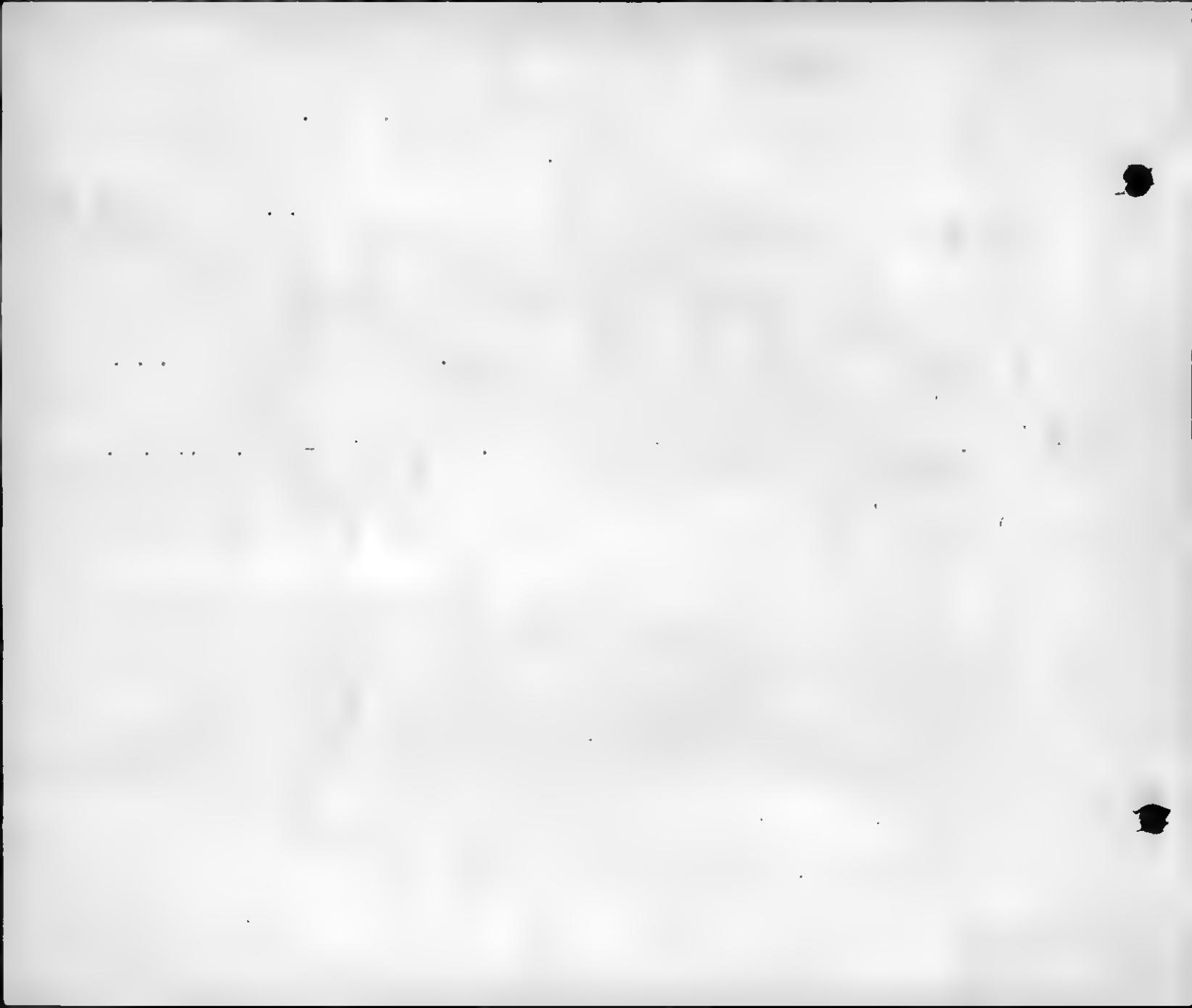
DATE DEC 2 '59

24b. REGISTRAR'S SIGNATURE

Ortho & Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

V.S. ATME(S)
SM 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12741

CERTIFICATE OF DEATH

12706

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|----------------------------------|---|-----------------------------------|--|---------------------------------------|---|---------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE West Virginia | | b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN lb 10 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shinnston | | d. STREET ADDRESS 52 Mahlon | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md. | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Paul | Middle Watters | Last EWING | 4. DATE OF DEATH | Month November | Day 2 | Year 1959 |
| S. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH 7-6-02 | 9. AGE (In years last birthday) 57 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS Days 0 | Hours 0 |
| 10a. US/JAI OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) New Jersey | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Watters EWING | | | | 14. MOTHER'S MAIDEN NAME Emily LITTLE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 236 50 8861 | | INFORMANT (Wife) Mrs. Paula Ewing Same as #2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. 4445X (b) Hypertensive Cardiovascular disease DUE TO (c) Chronic Hypertension + Myocardial infarction DUE TO | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 2 years | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 23 October 1959 | | | | | | | |
| 21. I certify that I attended the deceased from 23 October 1959 to 2 November 1959 , that I last saw the deceased alive on 2 November 1959 , and that death occurred at 10:20P M, from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) | | | | | | | |
| DATE SIGNED 11-8-59 | | | | | | | |
| ACTUAL SIGNATURE F.H. O'Connell | | M.D. U.S. Naval Hospital, Bethesda, Md. | | | | | |
| PHYSICIAN'S NAME (Type) F.H. O'CONNELL LCDR MC USN | | U.S. Naval Hospital, Bethesda Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11-5-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Stinger Hill | | 22d. LOCATION (City, town, or county) (State) Fort Loudin Penn. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey | | ADDRESS 7557 Wisconsin Ave. Bethesda Md. | | 24a. REC'D BY REGISTRAR NOV 6 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

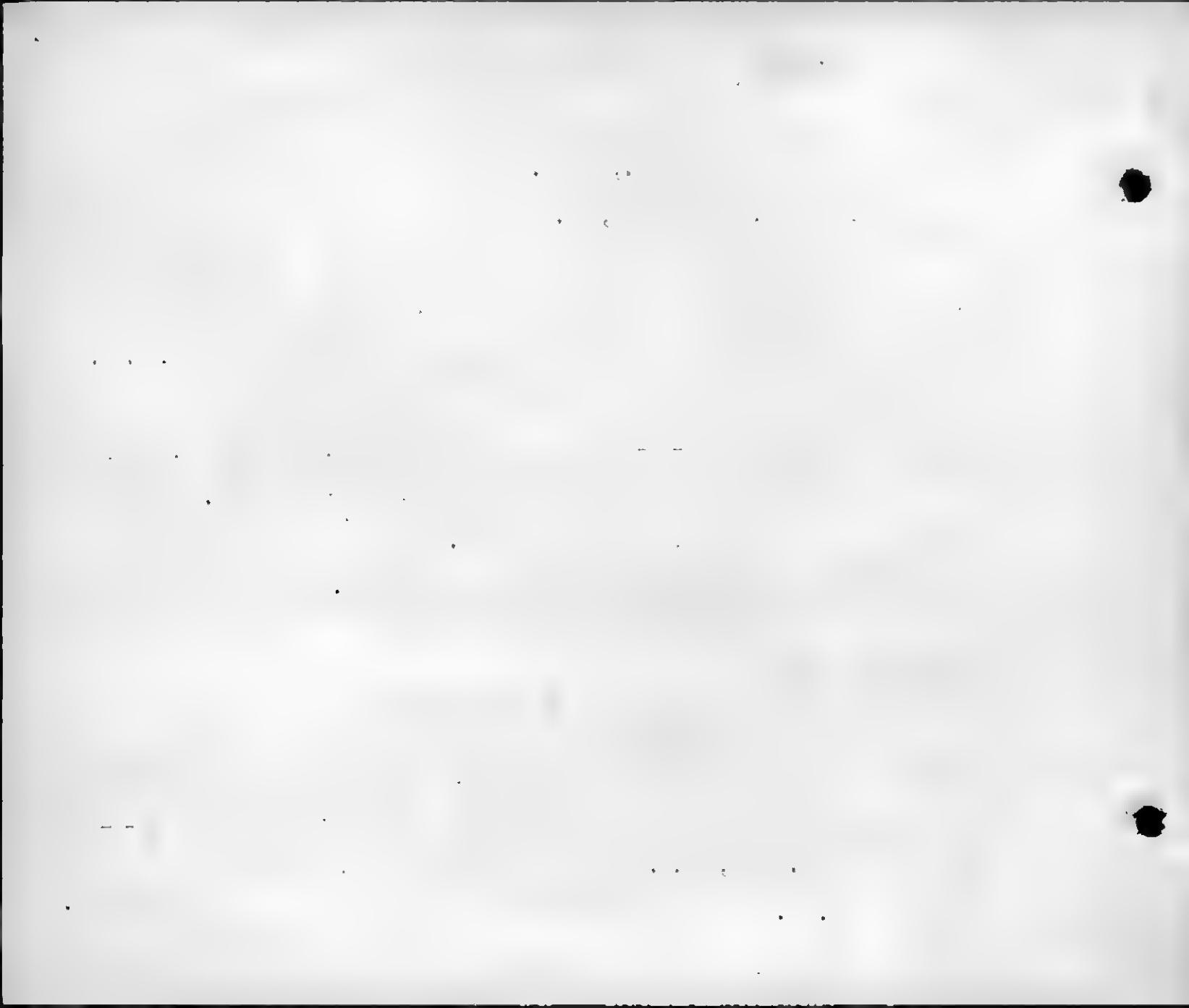
12742

CERTIFICATE OF DEATH

Reg. Dist. No.

12742

| | | | | | | | | | | | |
|---|----------------------------------|---|---|--|---------------------------------------|---|---------------------|-------------------------------|---|--|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. STATE Maryland | | b. COUNTY Washington | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN lb 12 Hrs., 50 Min. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | d. STREET ADDRESS 323 Myers Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | First JAMES | Middle ARTHUR | Last FAITH | 4. DATE OF DEATH November 7, 1959 | Month November | Doy 7 | Year 1959 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH May 14, 1915 | 9. AGE (In years last birthday) 44 | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS Days 0 | Hours 0 | Min 0 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | | 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | |
| 13. FATHER'S NAME Erastus Faith | | | | 14. MOTHER'S MAIDEN NAME Bertha Barnhart | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO 220-18-0148 | | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) Increased Intracranial Pressure PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) leading to pressure cone & Respiratory Failure. INTERVAL BETWEEN ONSET AND DEATH 24 Hours DUE TO Metastatic Malignant Melanoma of the Right Parietal Frontal Lobe of the Brain. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Malignant Melanoma of the Left Calf. 1 Month (c) Malignant Melanoma of the Left Calf. 23 Months | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Hancock | | (County) Washington | (State) Md. | | |
| 21. I certify that I attended the deceased from November 7, 1959 to November 7, 1959 , that I last saw the deceased alive on November 7, 1959 , and that death occurred at 10:30 P.M. from the causes and on the date stated above | | | | | | | | | ADDRESS (Street, city or town, state) The Clinical Center | DATE SIGNED 11-8-59 | |
| ACTUAL SIGNATURE <i>Seymour C. Nash M.D.</i> | | | | | | | | | National Institutes of Health Bethesda 14, Maryland | | |
| PHYSICIAN'S NAME (Type) SEYMORE C. NASH, M.D. | | 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | 22b. DATE THEREOF 11.10.59 | 22c. NAME OF CEMETERY OR CREMATORIUM House of Jacob Cemetery | 22d. LOCATION (City, town, or county) Hancock Washington |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard J. Stone Hancock Md</i> | | | | | | | | | 24a. REC'D BY REGISTRAR DATE NOV 12 '59 | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12677

CERTIFICATE OF DEATH

Reg. Dist. No.

12708

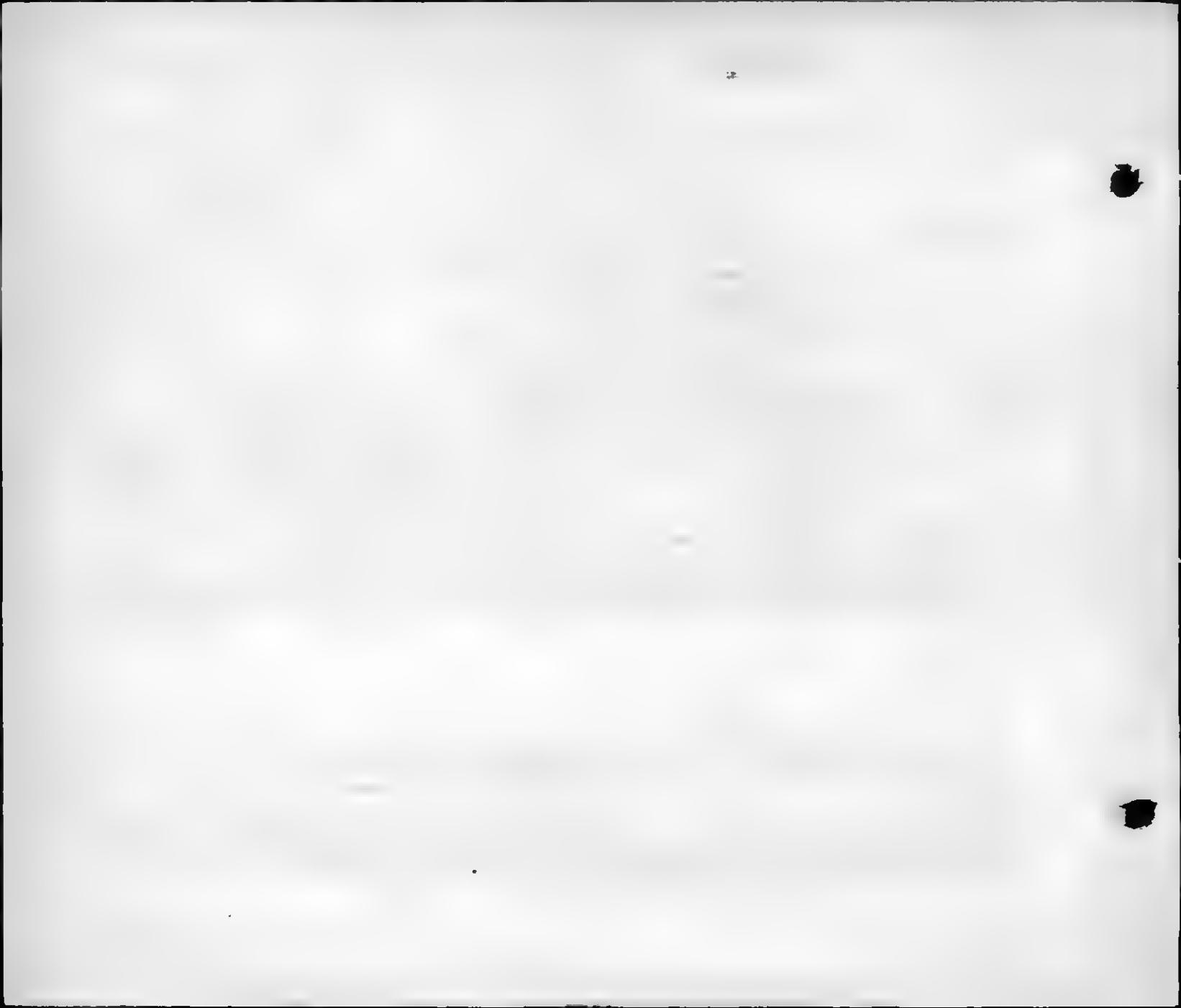
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

| | | | | | |
|---|--|---|---|---|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | MARYL | 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | c. LENGTH OF STAY IN 1b <i>28 days</i> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | | b. COUNTY <i>Montgomery</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Mortuary</i> | e. STREET ADDRESS <i>8520-Greenwood Ave</i> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Christina Tamara Fajen</i> | First <i>Christina</i> | Middle <i>Tamara</i> | Last <i>Fajen</i> | 4. DATE OF DEATH <i>11 28 1959</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>10-30-59</i> | 9. AGE (In years lost birthday) yrs <i>28</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>—</i> | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Clifford Walter Fajen</i> | | 14. MOTHER'S MAIDEN NAME <i>Lucille Corbin</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO <i>None</i> | 17. INFORMANT <i>Charlotte Clifford Fajen, 8520 Greenwood Ave</i> | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>776X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. <i>(b)</i> DUE TO <i>Prematurity.</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 20d. INJURY OCCURRED p. m. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 21. I certify that I attended the deceased from <i>10-30</i> , 19 <i>59</i> , to <i>11-28</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>11-27</i> , 19 <i>59</i> , and that death occurred at <i>8:25 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Winston E. Cochran</i> M.D. <i>927 Pershing Av., S. L. Spr., Md.</i> PHYSICIAN'S NAME (Type) <i>Winston E. Cochran</i> 927 Pershing Av. S. L. Spr., Md. | | | | ADDRESS (Street, city or town, state) <i>927 Pershing Av., S. L. Spr., Md.</i> | DATE SIGNED <i>11-28-59</i> |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>12/1/59</i> | 22c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington National</i> | 22d. LOCATION (City, town, or county) <i>Ft. Myer, Va.</i> | (State) <i>12/1/59</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chamberlain</i> | ADDRESS <i>1400 Franklin St. N.W. S. D.C.</i> | 24a. REC'D BY REGISTRAR <i>DEC 1 '59</i> | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i> | | |

212 - 42XVI



1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH43. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

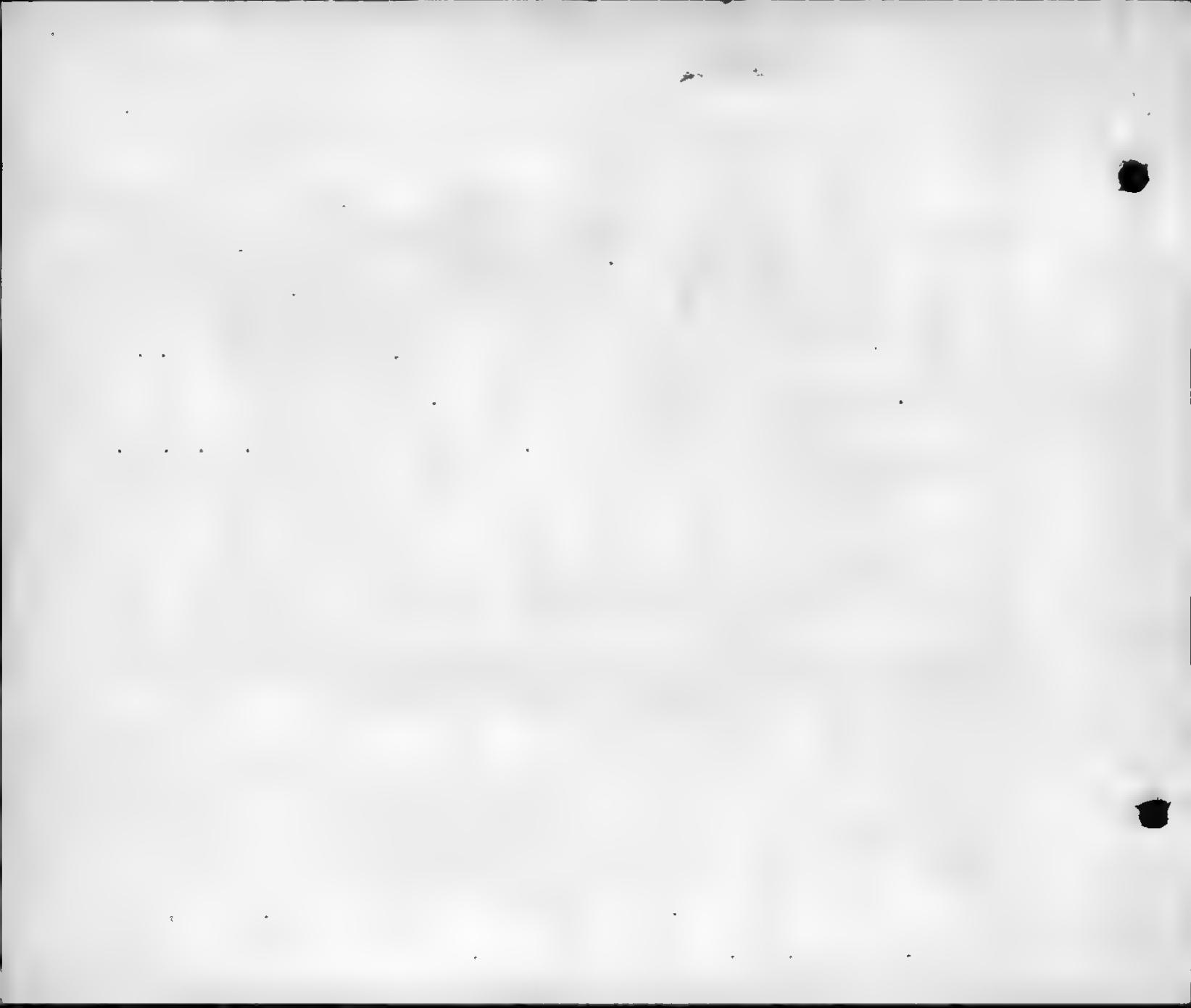
Item PC Fil. 226

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12769

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md ryl n. b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN lb 18 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Wheaton | |
| 3. NAME OF DECEASED (Type or print) William | | First H. | Middle Feldbush |
| 4. DATE OF DEATH 11 | Month 10 | Day 1959 | Year |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH 1/7/03 |
| 9. AGE (In years last birthday) 56 yrs. | | 10. IF UNDER 1 YEAR Months 5 | 11. IF UNDER 24 HRS. Hours 17 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | | 10b. KIND OF BUSINESS OR INDUSTRY Painter | |
| 11. BIRTHPLACE (State or foreign country) Canton, Ohio | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME John W. Feldbush | | 14. MOTHER'S MAIDEN NAME Mary E. Mock | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 57-07-8526 | 17. INFORMANT Mr. Parsons - 602 Easly St., S. S. Md. |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 900.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | Cerebral Contusion & Subdural Hemorrhage 17 days | |
| (b) Fracture of skull | | | |
| (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down basement steps at home | |
| 20c. TIME OF INJURY Hour even. 10-23 1959 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home |
| | | 20f. (City or town) wheaton | (County) montgomery (State) md |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) FRANK J. Broschart | | 11-10-59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 11/13/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY | | 22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziskin | | ADDRESS SILVER SPRING, MD. | |
| 24a. REC'D BY REGISTRAR DATE NOV 13 '59 | | 24b. REGISTRAR'S SIGNATURE Curtis & Tracy | |



TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

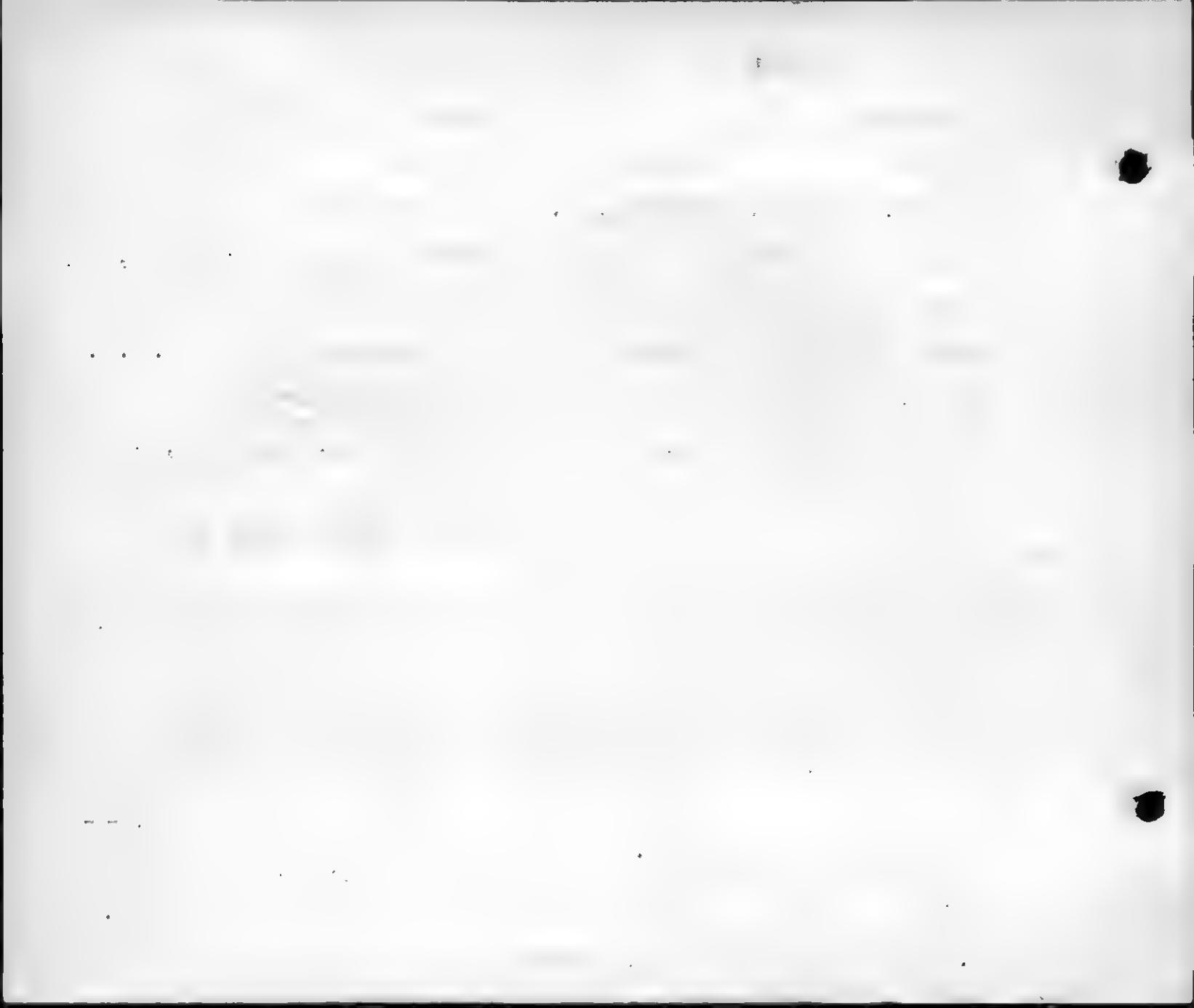
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12744

CERTIFICATE OF DEATH

Reg. Dist. No. 12710

| | | | | | | | | |
|---|---|--|--|--|--|---|---------------------------------------|----------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia | | b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN lb 4 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | d. STREET ADDRESS 2 Prospect Terrace | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) | First KEVIN | Middle MICHAEL | Last FLATTERY | 4. DATE OF DEATH November 6, 1959 | Month November | Day 6 | Year 1959 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH June 16, 1946 | 9. AGE (In years last birthday) 13 yrs | IF UNDER 1 YEAR Months 0 | Days 0 | IF UNDER 24 HRS. Hours 0 | Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | 10b. KIND OF BUSINESS OR INDUSTRY none | 11. BIRTHPLACE (State or foreign country) New York | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | |
| 13. FATHER'S NAME Matthew Flattery | | | 14. MOTHER'S MAIDEN NAME Adele Viningre | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. none | INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 343X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) RESPIRATORY DUE TO (c) CEREBRAL INTERVAL BETWEEN ONSET AND DEATH 11 days | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month 19 | Day | Year | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) Fort Myer | (County) Virginia | (State) Virginia |
| 21. I certify that I attended the deceased from November 2, 1959 , to November 6, 1959 , that I last saw the deceased alive on November 6, 1959 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 11-7-59 | | | | | | | | |
| ACTUAL SIGNATURE <i>Steven Schenker</i> | The Clinical Center National Institutes of Health Bethesda 14, Maryland | | | | | | | |
| PHYSICIAN'S NAME (Type) STEVEN SCHENKER, M.D. | | | | | | | | |
| 22a. BURIAL, CREMATON, REMOVAL (Specify) Burial | 22b. DATE THEREOF 11-10-59 | 22c. NAME OF CEMETERY OR CREMATORIUM Arlington National Cemetery | 22d. LOCATION (City, town, or county) Fort Myer, Virginia. | (State) Virginia | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Demaine & Son Funeral Home, Alexandria, Va. | ADDRESS John W. Murray | 24a. REC'D BY REGISTRAR NOV 12 '59 | 24b. REGISTRAR'S SIGNATURE Robert S. Keene | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12711

Reg. Dist. No. 215

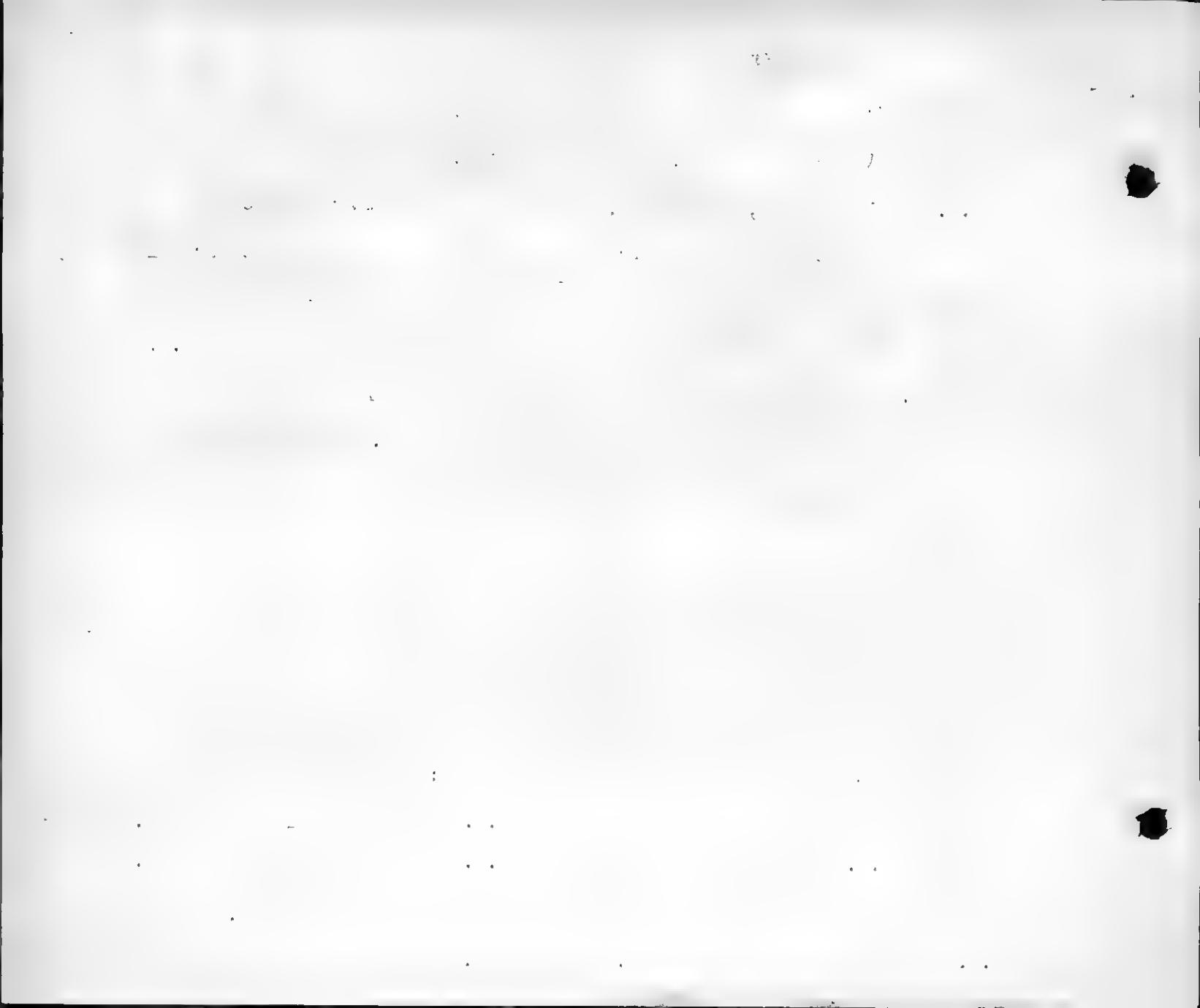
12745

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|--|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maine | |
| b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 14 days | | d. C T Y OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burnswick | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Laura | | First | Middle Lucile | Last FOLSOM | 4. DATE OF DEATH Month November Day 17 Year 1959 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH 3-9-55 | 9. AGE (In years last birthday) 4 yrs. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Washington | |
| 13. FATHER'S NAME Riley T. Folsom | | 14. MOTHER'S MAIDEN NAME Eudora ISBELL | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO None | | INFORMANT (Father) Riley T. Folsom Same as #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Medulloblastoma | | DUE TO 1939 | | INTERVAL BETWEEN ONSET AND DEATH 28 mos. | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3 November , 1959, to 17 November , 1959, that I last saw the deceased alive on 17 November , 1959, and that death occurred at 4:45 PM , from the causes and on the date stated above. | | | | | |
| ADDRESS (Street, city or town, state) W.H. Druckemiller M.D. U.S. Naval Hospital, Bethesda Md. 11-18-9 | | | | | |
| DATE SIGNED | | | | | |
| ACTUAL SIGNATURE W.H. Druckemiller | | PHYSICIAN'S NAME (Type) W.H. DRUCKEMILLER CAPT MC USN U.S. Naval Hospital, Bethesda Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11-29-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Arlington National | |
| 22d. LOCATION (City, town, or county) Arlington Va. | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey | | ADDRESS 7357 Wisconsin Ave. Bethesda Md. | | 24a. REC'D BY REGISTRAR DATE NOV 19 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Charles S. Trahan | |



TO HOSPITAL OR may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

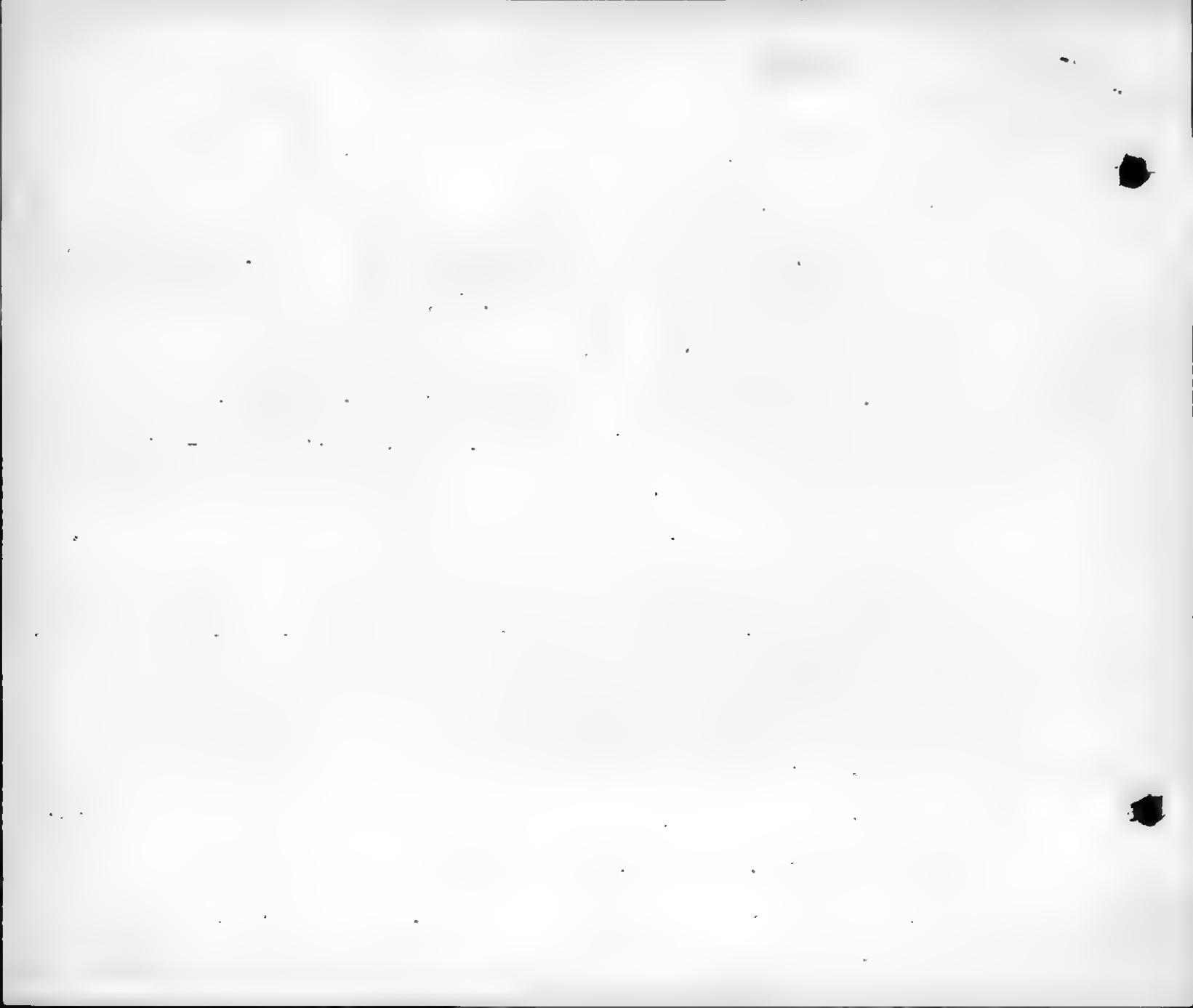
12698

CERTIFICATE OF DEATH

Reg. Dist. No.

12712

| | | | | | | | | | | | |
|---|--|--|---|---|---------------------------------|--|------------------|---|------|--------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE | | Maryland | | b. COUNTY | | Montgomery | |
| Montgomery | | | | c. LENGTH OF STAY IN lb | | Rockville | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | RURAL | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | 620 Great Falls Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 52 Rockville | | | | | | d. STREET ADDRESS | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | 620 Great Falls Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle | Last | 4. DATE OF DEATH | Month | Day | Year | | | |
| BIRDIE | | VIOLA | FORMWALT | Nov. 16 1959 | | | | | | | |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | | | | |
| Female | | White | | Oct. 10, 1876 | 83 yrs. | Months 1 | Days 6 | Hours | Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12 CITIZEN OF WHAT COUNTRY? | | | | | |
| Housewife | | Own Home | | Maryland | | US | | | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | | | | | | | |
| John N. Mark | | Augusta J. Morelock | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | INFORMANT | | Address | | | | | |
| (If yes, give war or dates of service) | | None | | Mary V. deVermond-daughter-same as 2d | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary occlusion | | | | | | | | | | | |
| 420.1 DUE TO | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) essential hypertension | | | | | | | | | | | |
| DUE TO | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 2 hours | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 2. yes | | | | | | | | | | | |
| arteriosclerotic cardiovascular disease | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) none | | 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| | | | | | | | | | | | |
| 21. I certify that I attended the deceased from Nov. 13, 1959, to Nov. 16, 1959, that I last saw the deceased alive on Nov. 16, 1959, and that death occurred at 10 AM, from the causes and on the date stated above. | | | | | | | | | | | |
| ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | | | | | |
| ACTUAL SIGNATURE Stephen C. Cromwell, M.D. 65 W. Maryland Ave. 10/16/59 | | | | | | | | | | | |
| PHYSICIAN'S NAME (Type) | | Stephen C. Cromwell | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORIUM | | 22d. LOCATION (City, town, or county) | | (State) | | | |
| Burial | | 11/18/59 | | East Harrisburg Cem. | | Harrisburg, Pennsylvania | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | | | | | |
| Robert A. Pumphrey | | Bethesda, Maryland | | DATE NOV 18 '59 | | Cathleen S. Turner | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12713

CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

| | | | | | | | | |
|---|--|--|---|--|---|---|-------------------------------------|---------------------|
| 12745 | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institut on Residence before admission) a. STATE Maryland | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 13 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md. | | | | d. STREET ADDRESS 201 Lee Street Apt. 4 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) Doreen | | First (n) | Middle (n) | Last FOSTER | 4. DATE OF DEATH November 25 1959 | Month November | Day 25 | Year 1959 |
| 5. SEX Female | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | B. DATE OF BIRTH 3-7-05 | 9. AGE (In years last birthday) 54 yrs. | IF UNDER 1 YEAR Months 54 | IF UNDER 24 HRS Days 0 | Hours 0 |
| WIDOWED <input type="checkbox"/> | | DIVORCED <input type="checkbox"/> | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) India | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | |
| 13. FATHER'S NAME Frederick REGNAUD | | 14. MOTHER'S MAIDEN NAME Violet VAUGHN | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (Husband) Francis Foster | | INFORMANT Same as #2 | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 151X DUE TO Carcinomatosis INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Carcinoma of Stomach 1½ yrs (c) | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| MEDICAL CERTIFICATION | | 20c. TIME OF INJURY Hour a. m. p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) U.S. Naval Hospital, Bethesda Md. | (County) Prince George County | (State) MD | |
| 21. I certify that I attended the deceased from 12 November 1959 to 25 November 1959 , that I last saw the deceased alive on 25 November 1959 , and that death occurred at 8:45 AM from the causes and on the date stated above. | | | | | | | | |
| ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 11-25-59 | | | | | | | | |
| ACTUAL SIGNATURE C.U. Bramlett | | PHYSICIAN'S NAME (Type) C.U. BRAMLETT LT MC USN U.S. Naval Hospital, NNMC, Bethesda, Md. | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 11-27-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln | | 22d. LOCATION (City, town, or county) Prince George County (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler | | ADDRESS 1331 E. Montgomery Ave. Rockville | | 24a. REC'D BY REGISTRAR NOV 3 0 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12714

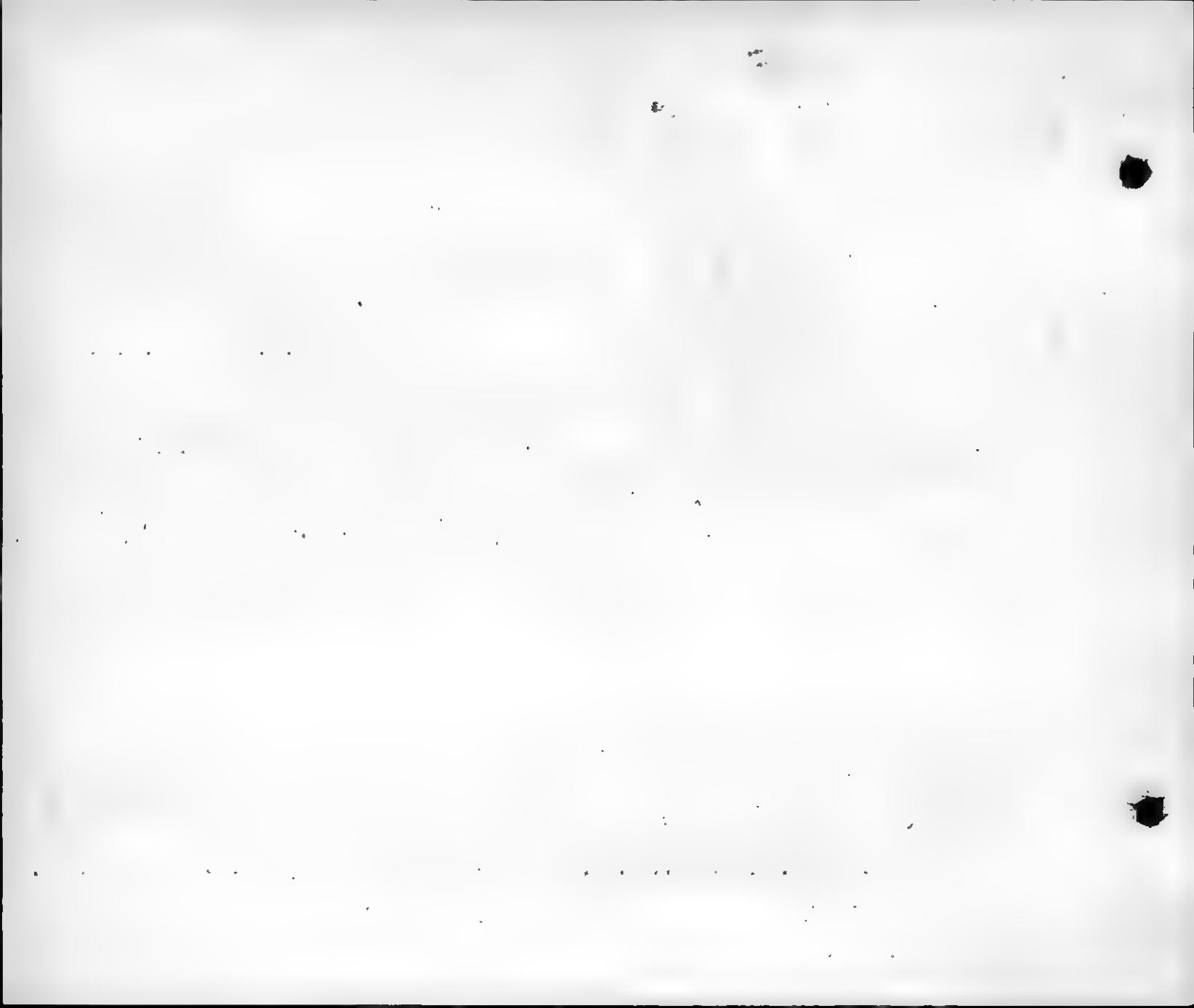
12747

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|-----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney - Rural | | c. LENGTH OF STAY IN 1b 13 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brooke Grove Foundation | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chevy Chase | |
| 3. NAME OF DECEASED (Type or print) ANNIE JEANNETTE | | First MIDDLE Last | 4. DATE OF DEATH November 17, 1959 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 13, 1877 |
| WIDOWED <input type="checkbox"/> | DIVORCED <input type="checkbox"/> | 9. AGE (In years last birthday) 82 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Henry High | | 14. MOTHER'S MAIDEN NAME Sarah Mitchell | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None INFORMANT Mrs. Dorothy Leef-Item #2-Daughter Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) | | INTERVAL BETWEEN ONSET AND DEATH Congestive heart failure. 2/10/45P-11/11/59 | |
| 4. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b) due to Arteriosclerotic heart disease. c) chronic pulmonary emphysema | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from alive on and that death occurred at M, from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| ACTUAL SIGNATURE George A. Gray, Jr., M.D. | | M.D. November 18, 1959 | |
| PHYSICIAN'S NAME (Type) George A. Gray, Jr., M.D. | | 1422 East West Highway, Bethesda, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 11-18-59 | 22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory |
| 22d. LOCATION (City, town, or county) Suitland, Maryland | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland | | 24a. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE Charles L. Kline |
| | | DATE NOV 20 '59 | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12748

CERTIFICATE OF DEATH

12715

Reg. Dist. No.

| | | | | | | | | |
|--|--|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <i>Maryland</i> | | b. COUNTY <i>Montgomery</i> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney</i> | | c. LENGTH OF STAY IN 1b <i>1 mo 21 days</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i> | | d. STREET ADDRESS <i>Brooke Grove Chronic Hosp #6707 East Ave -</i> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Chronic Hosp</i> | | | | d. STREET ADDRESS <i>SK</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | | First <i>Barron</i> | Middle <i>R.</i> | Lost <i>SK</i> | 4. DATE OF DEATH <i>Nov 24 1959</i> | Month <i>Nov</i> | Day <i>24</i> | Year <i>1959</i> |
| 5. SEX <i>Male</i> | | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>July 12-1877</i> | | 9. AGE (In years lost birthday) <i>82 yrs.</i> | 10. IF UNDER 1 YEAR Months <i>0</i> | 11. IF UNDER 24 HRS Days <i>0</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Internal Revenue Inspector</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>None</i> | | 11. BIRTHPLACE (State or foreign country) <i>Virginia</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | |
| 13. FATHER'S NAME <i>James S. Franklin</i> | | 14. MOTHER'S MAIDEN NAME <i>Alice Rebecca Barron</i> | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>No</i> | | 17. INFORMANT <i>Dorothy F. Leef-daughter-same as 2d</i> | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Diabetes Mellitus</i> DUE TO <i>260x</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>Oct 11, 1957</i> | | 20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i> | | 20f. (City or town) <i>Sandy Spring</i> | (County) <i>Montgomery</i> | (State) <i>Md.</i> |
| 21. I certify that I attended the deceased from <i>Oct 11, 1957</i> , to <i>Nov 24, 1959</i> , that I last saw the deceased alive on <i>Nov. 3, 1959</i> , and that death occurred at <i>3 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>S. H. Wiggin</i> DATE SIGNED <i>Nov 24, 1959</i> PHYSICIAN'S NAME (Type) <i>S. H. Wiggin</i> ADDRESS <i>Sandy Spring, Maryland</i> | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i> | | 22b. DATE THEREOF <i>11-24-59</i> | | 22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Crematory</i> | | 22d. LOCATION (City, town, or county) (State) <i>Prince George County, Md.</i> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i> | | ADDRESS <i>Bethesda, Md.</i> | | 24a. REC'D BY REGISTRAR DATE <i>NOV 27 '59</i> | | 24b. REGISTRAR'S SIGNATURE <i>Charles E. Tracy</i> | | |

8.00 ft

TO HOSPITAL may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

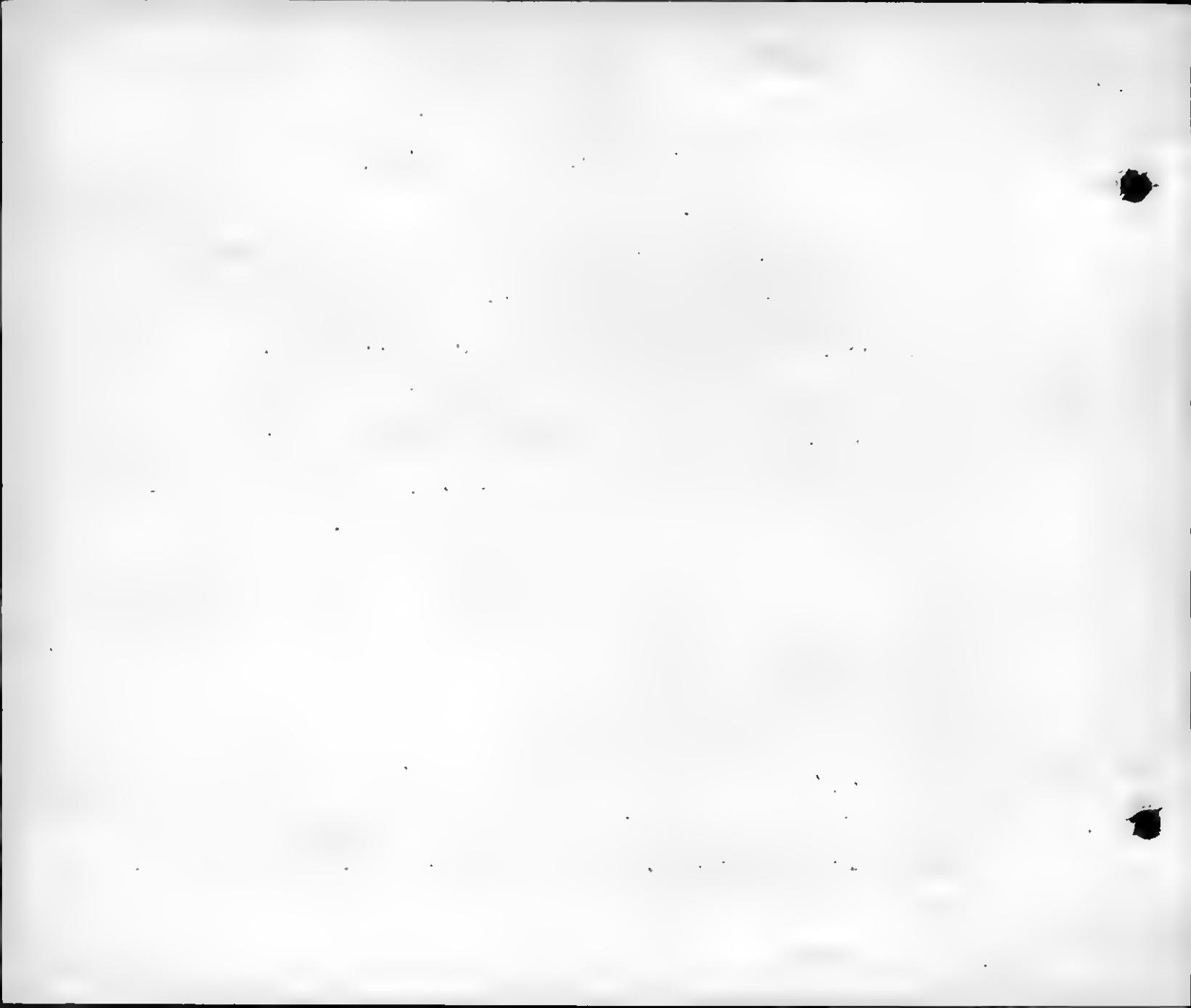
12749

CERTIFICATE OF DEATH

12716

Reg. Dist. No.

| | | | | | | | | |
|--|--|--|---|--|---|--|------------------------------------|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland | | b. COUNTY Montgomery | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN lb 32 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | d. STREET ADDRESS 5331 Chamberlin Avenue | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5331 Chamberlin Avenue | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) MORRISON | | First | Middle | Last | 4. DATE OF DEATH November 3, 1959 | Month | Day | Year |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 14, 1885 | 9. AGE (In years last birthday) 75 yrs. | IF UNDER 1 YEAR 11 months | IF UNDER 24 HRS 20 hours | IF UNDER 24 MRS Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Const. Supt. | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (State or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME William French | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. WW I 578-20-9947 | | INFORMANT Ethel C. French- Wife - Item #2 | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH 420.1 Instinct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease 6 month (c) Endocarditis ? DUE TO DUE TO DUE TO | | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from 7-13-1957 to 10-3-1957 , that I last saw the deceased alive on 10-6-1957 , and that death occurred at 7:24 P.M. from the causes and on the date stated above. | | | | | | | | |
| ACTUAL SIGNATURE <i>Francis T. Sharpe</i> | | ADDRESS (Street, city or town, state) M.D. 3323-0-81, Washington D.C. DATE SIGNED <i>Arthur S. Krause</i> | | | | | | |
| PHYSICIAN'S NAME (Type) Francis T. Sharpe, M. D. | | 3323-0, St. N. W. Wash. D. C. | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL Cremation | | 22b. DATE THEREOF 11-5-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Crematory | | 22d. LOCATION (City, town, or county) Suitland, Maryland (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland | | ADDRESS | | 24a. REC'D BY REGISTRAR NOV 6 '59 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i> | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12717

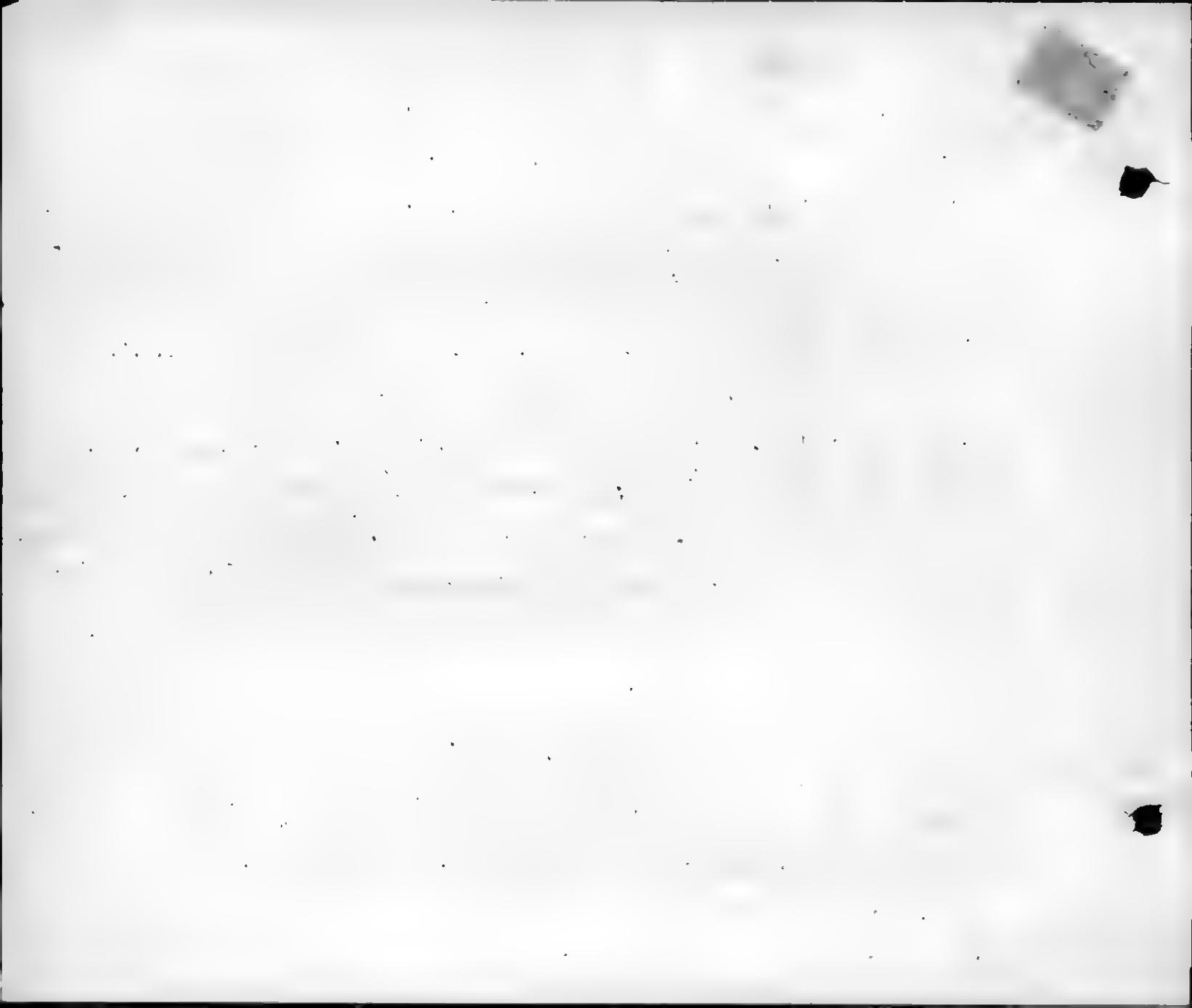
12750

CERTIFICATE OF DEATH

Reg. Dist. No.

X1
TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | |
|--|--|---|---|---|---|--|-------------------------|-------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Montgomery | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 7 days 2 hr. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | d. STREET ADDRESS 5908 Aberdeen Road | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) Walter | | First | Middle | Last | 4. DATE OF DEATH Nov. | Month | Day | Year |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH 8 - 9 - 1892 | 9. AGE (In years last birthday) 67 yrs | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Film Technologist (retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Lib. of Cong. | | 11. BIRTHPLACE (State or foreign country) Texas | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Gannaway | | 14. MOTHER'S MAIDEN NAME Mary Bouvet | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes | | 16. SOCIAL SECURITY NO. March 17-Jan. 19 None | | INFORMANT Louise P. Gannaway 5908 Aberdeen RD, Md. | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | Bilateral confluent bronchopneumonia | | INTERVAL BETWEEN ONSET AND DEATH 3-4 DAYS | | |
| (b) | | DUE TO | | Esophago-bronchial fistulas | | UNDETERMINED | | |
| (c) | | DUE TO | | Bronchogenic carcinoma post irradiation | | 60 DAYS | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Doy, Year Hour p. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) 20g. (County) (State) | | | | |
| 19 | | | | | | | | |
| 21. I certify that I attended the deceased from <u>ASOUT</u> <u>9/11</u> , 19 <u>59</u> , to <u>NOV 12</u> , 19 <u>59</u> , that I lost sight of the deceased alive on <u>11/12</u> , 19 <u>59</u> , and that death occurred at <u>9⁰⁶</u> A.M. from the causes and on the date stated above. | | ACTUAL SIGNATURE <i>John H. Tuohy</i> | | ADDRESS (Street, city or town, state) 7720 WISCONSIN AVE BETHESDA 14, MD. | | DATE SIGNED 11/12/59 | | |
| PHYSICIAN'S NAME (Type) John H. Tuohy | | | | | | | | |
| 22a. BURIAL, CREMAT. ON, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 11/12/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Crematory | | 22d. LOCATION (City, town, or county) Suitland, Maryland (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Maryland | | 24a. REC'D BY REGISTRAR NOV 13 '59 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12718

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY COUNTY</i> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Tennessee</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i> | c. LENGTH OF STAY IN lb <i>1b</i> | b. COUNTY <i>Patterson</i> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Memphis, Tennessee</i> |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Visiting from Shreveport La. & 4. sp</i> | | d. STREET ADDRESS <i>17315 Flower Ave.</i> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First <i>Esther</i> | Middle <i>Ann</i> | Last <i>Plumley</i> |
| 4. DATE OF DEATH <i>Nov. 19 1957</i> | Month <i>Nov.</i> | Day <i>19</i> | Year <i>1957</i> |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>1887</i> |
| 9. AGE (In years last birthday) <i>60 yrs.</i> | 10. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i> | 11. BIRTHPLACE (State or foreign country) <i>Tenn.</i> | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> |
| 13. FATHER'S NAME <i>Joseph Roberts</i> | 14. MOTHER'S MAIDEN NAME <i>Estella Plumb</i> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i> | 16. SOCIAL SECURITY NO. <i>Address</i> | INFORMANT <i>Washington - Quakerian Hospital</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Small Bowel Obstruction</i> DUE TO <i>570.5</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Internal Mesenteric Strangulated hernia</i> DUE TO (c) <i>Adhesions from previous Surgery</i> | | | |
| INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month <i>Nov.</i> | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>James</i> |
| 20f. (City or town) <i>James</i> | (County) <i>James</i> | (State) <i>James</i> | |
| 21. I certify that I attended the deceased from <i>James</i> , 1957, to <i>Nov. 19</i> , 1957, that I last saw the deceased alive on <i>Nov. 18</i> , 1957, and that death occurred at <i>3:30 AM</i> , from the causes and on the date stated above | | | |
| ACTUAL SIGNATURE <i>James M. Whitlock</i> | | | ADDRESS (Street, city or town, state) <i>Takoma Park Md.</i> |
| DATE SIGNED <i>11/19/59</i> | | | |
| PHYSICIAN'S NAME (Type) <i>JAMES M. WHITLOCK</i> | | 22b. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | |
| 22b. DATE THEREOF <i>Nov. 23, 1959</i> | | 22c. NAME OF CEMETERY OR CREMATORIAL <i>Memorial Park</i> | |
| 22d. LOCATION (City, town, or county) <i>Memphis, Tennessee</i> | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Walters 254 Carroll Street, Md.</i> | | 24a. REC'D BY REGISTRAR DATE <i>NOV 23 '59</i> | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,2,4 Film G252 11-30-59 et

12719

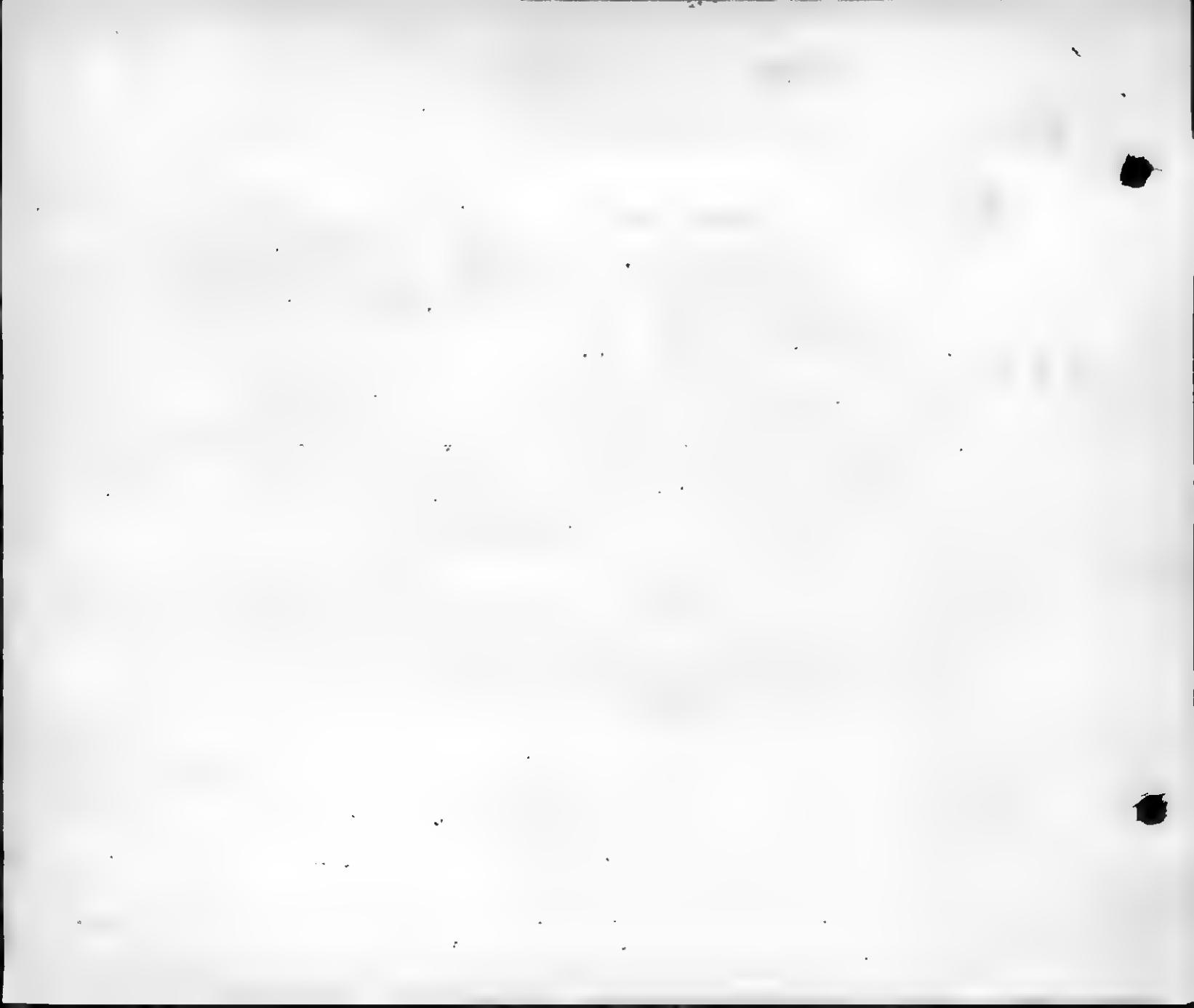
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | |
| d. LENGTH OF STAY IN 1b 8007 Marywood Road | | e. STREET ADDRESS 6607 6607 Marywood Road | |
| f. NAME OF HOSPITAL (If not in hospital, give street address) Regis | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| h. FIRST NAME George | | i. MIDDLE NAME F. | |
| j. LAST NAME George | | k. DATE OF DEATH Month Day Year 11 18, 1959 | |
| l. SEX Male | | m. COLOR OR RACE White | |
| n. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | o. DATE OF BIRTH June 6, 1908 | |
| p. AGE (In years lost birthday) 51 yrs. | | q. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min 5 11 | |
| r. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer | | s. 10b. KIND OF BUSINESS OR INDUSTRY Navy Dept. | |
| t. 11. BIRTHPLACE (State or foreign country) Penn | | u. 12. CITIZEN OF WHAT COUNTRY? US | |
| v. 13. FATHER'S NAME Walter J. George | | w. 14. MOTHER'S MAIDEN NAME Clara Fox | |
| x. 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | y. 16. SOCIAL SECURITY NO. 577-22-3542 | |
| z. 17. INFORMANT Regina George-wife-same as 2d | | aa. ADDRESS | |
| bb. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Melastatin Circumum</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acetyl Circumum & Cola</i> DUE TO (c) | | | |
| cc. INTERVAL BETWEEN ONSET AND DEATH 6 m 4 | | | |
| dd. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4 m - | | | |
| ee. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | ff. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| gg. 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | hh. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input checked="" type="checkbox"/> | |
| ii. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | jj. 20f. (City or town) (County) (State) | |
| kk. 21. I certify that I attended the deceased from Oct 15, 1959 to Nov 18, 1959 , that I last saw the deceased alive on Nov. 17, 1959 , and that death occurred at 1152 AM , from the causes and on the date stated above. ll. ADDRESS (Street, city or town, state) 8016 Lexington Road Hollidaysburg, Penna. mm. DATE SIGNED 11/19/59 | | | |
| nn. ACTUAL SIGNATURE <i>Leo J. Donovan</i> M.D. <i>14 May 1959</i> | | | |
| oo. PHYSICIAN'S NAME (Type) LEO J. DONOVAN M.D. | | pp. 22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 11/20/59 | |
| qq. 22b. DATE THEREOF 11/20/59 | | rr. 22c. NAME OF CEMETERY OR CREMATORIUM Green Lawn | |
| ss. 22d. LOCATION (City, town, or county) (State) Hollidaysburg, Penna. | | tt. 24a. REC'D BY REGISTRAR DATE NOV 23 '59 | |
| uu. 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | vv. 24b. REGISTRAR'S SIGNATURE Charles L. Krause | |
| ww. ADDRESS Bethesda, Maryland | | | |

TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12720

CERTIFICATE OF DEATH

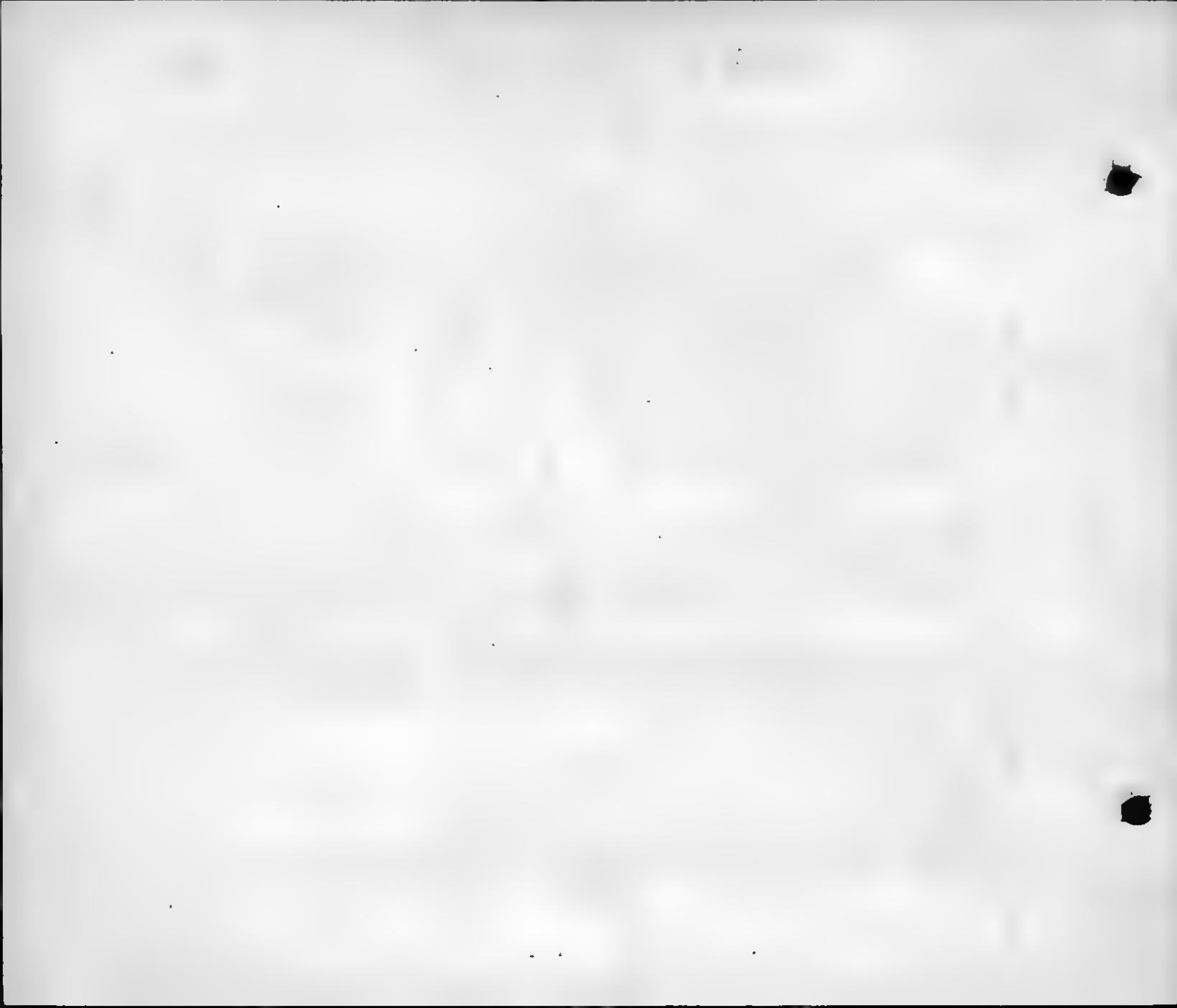
Reg. Dist. No.

| | | | | | | | |
|---|-----------------------|---|-------------------------------------|---|-----------------------------------|--|--------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE D.C. | | b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Lavarest Nursing Home | | d. STREET ADDRESS 1327 Monroe St. N.E. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First ISABEL | Middle C | Last GLADING | 4. DATE OF DEATH Oct 10 1959 | Month 11 | Day 9 | Year 1959 |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 10-1869 | 9. AGE (In years from birth) 90 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Mass. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Benjamin Newton | | 14. MOTHER'S MAIDEN NAME Sarah Greer | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Lois Wagner - 1327 Monroe St. N.E. L.C. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. | | DUE TO (b) Arteriosclerotic heart disease | | INTERVAL BETWEEN ONSET AND DEATH 2 days | | unknown | |
| DUE TO (c) Generalized arteriosclerosis | | | | | | unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct. 9, 1959, to Nov. 9, 1959, that I last saw the deceased alive on Nov. 9, 1959, and that death occurred at 2:02 P.M. from the causes and on the date stated above. | | | | ADDRESS (Street, city or town, state) | | DATE SIGNED 11/9/59 | |
| ACTUAL SIGNATURE EINO MAGI | | M.D. | | 918 University Blvd. E. | | | |
| PHYSICIAN'S NAME (Type) | | | | Silver Spring, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 11-1k-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Glenwood | | 22d. LOCATION (City, town, or county) Washington D.C. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home. Washington D.C. | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE NOV 12 '59 | | 24b. REGISTRAR'S SIGNATURE Cathleen S. Farina | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12721

| | | | | | | | | | | |
|--|----------------------------------|---|--|---|---|---|--------------------------|---------|------|---|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admisssion) a. STATE | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 95 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) The District of Columbia | | d. STREET ADDRESS 4815 North Capitol Street | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) SIDNEY | | First | Middle --- | Last GLICK | 4. DATE OF DEATH November 17, 1959 | Month | Day | Year | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH Aug 15, 1895 | 9. AGE (In years lost birthday) 64 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | Hours | Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY Paper Company | | 11. BIRTHPLACE (State or foreign country) Poland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | |
| 13. FATHER'S NAME Jacob Glick | | 14. MOTHER'S MAIDEN NAME Sara (unknown) | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 100-03-5500 not available | | INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma to brain DUE TO 177X Conditions if any, which give rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Carcinoma of prostate gland (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH months |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | 2 $\frac{1}{2}$ yrs. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | (State) | | |
| 21. I certify that I attended the deceased from August 14, 1959 , to November 17, 1959 , that I last saw the deceased alive on November 17, 1959 , and that death occurred at 2:10 PM , from the causes and on the date stated above. | | | | | | | | | | |
| ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11-17-59 | | | | | | | | | | |
| ACTUAL SIGNATURE Gordon C. Sharp, M.D. | | | | | | | | | | |
| PHYSICIAN'S NAME (Type) Gordon C. Sharp, M.D. | | National Institutes of Health Bethesda 14, Maryland | | | | | | | | |
| 22. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/19-1959 | | 22c. NAME OF CEMETERY OR CREMATORIUM Geo Wash Cem | | 22d. LOCATION (City, town, or county) Nyacksville, Md | | (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Golding Funeral Home | | ADDRESS 4217 9th Street | | 24a. REC'D BY REGISTRAR DATE NOV 20 '59 | | 24b. REGISTRAR'S SIGNATURE C. E. S. Kraus | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12722

| | | | | | | | |
|---|--|---|---|--|---|---|-------------------------------|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | | | | |
| Montgomery, MARYLAND | | Washington, DC | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN lb RURAL and give nearest town) | | | | | |
| Bethesda | | 1 wk. | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 4604 S. Chelsea Lane | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle | | | | |
| Mary J. Quinlan | | Guy | Line | | | | |
| 4. DATE OF DEATH | | Month | Day | | | | |
| Nov 10 | | Year | 1959 | | | | |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) 84 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS Hours Min. |
| Fe | | Wh- | | 5/24/810 (?) | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Retired | | Seamstress | | Ireland | | U.S.A | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | | | |
| James Quinlan | | Anna Hanlon | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no | | 16. SOCIAL SECURITY NO | | 17. INFORMANT | | Address | |
| | | | | S. E. Proctor 4604 S. Chelsea Lane Bethesda, Md | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Acute coronary occlusion | | | | terminal. | |
| 420.0 | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| (b) | | Arteriosclerotic hypertension heart | | | | years | |
| DUE TO | | | | | | 1951-56 | |
| (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| Hour a.m. p.m. | | 19 | | | | | |
| 21. I certify that I attended the deceased from May 1954 to Nov 16, 1959, that I last saw the deceased alive on Oct 21, 1959, and that death occurred at 10:15 A.M. from the causes and on the date stated above. | | | | | | ADDRESS (Street, city or town, state) | |
| ACTUAL SIGNATURE | | William J. Simpson, Jr. | | | | DATE SIGNED | |
| MD | | 1016 N. 4th Ave. A.E. | | | | 11/10/59 | |
| PHYSICIAN'S NAME (Type) | | Washington, D.C. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORIAL | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | 11/13/59 | | Mt. Olivet | | Washington D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | |
| Frank Geers Sons Co 3605-14 St | | Wash. D.C. | | NOV 13 '59 | | Crown & Thorne | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

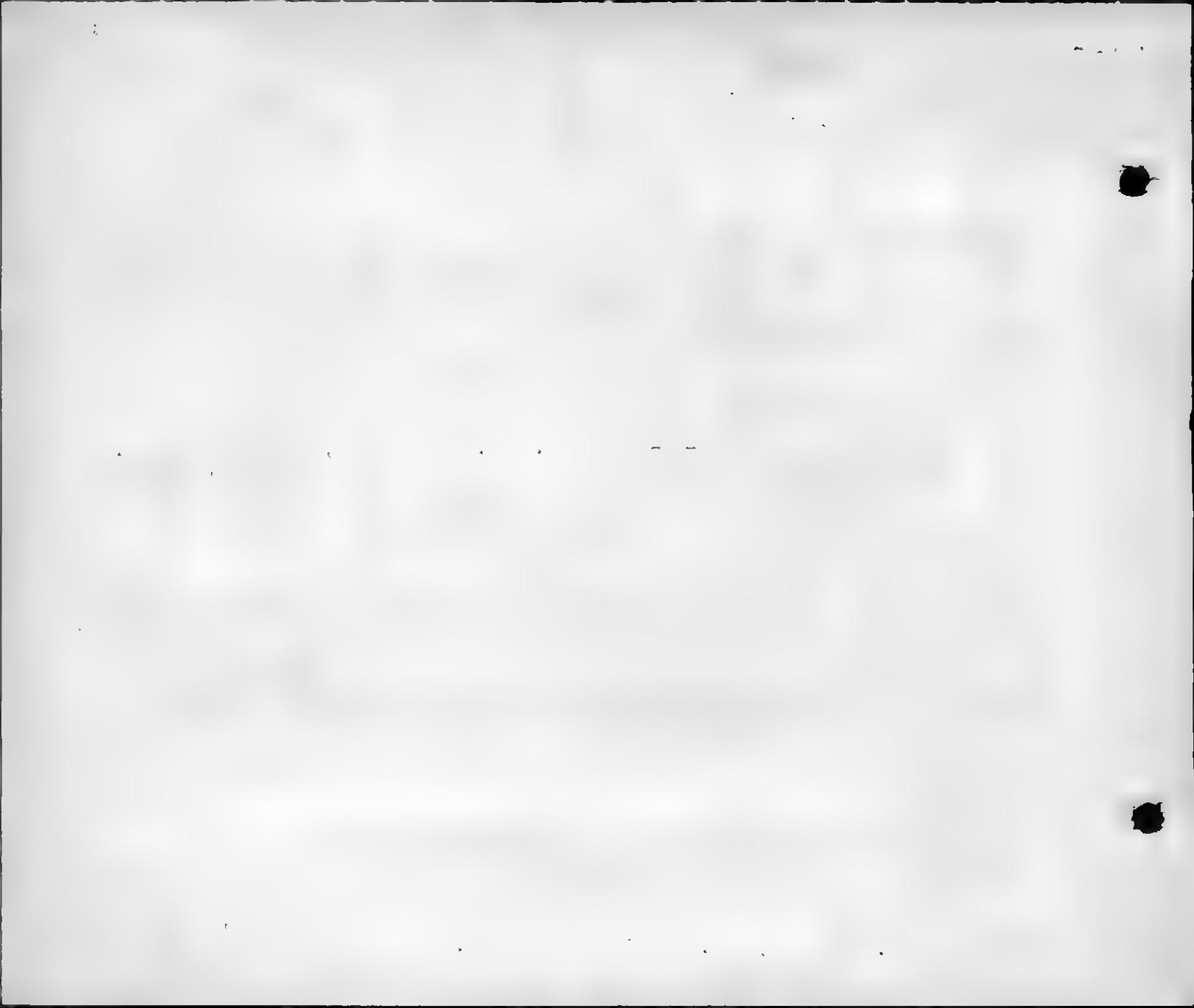
12723

Reg. Dist. No.

12755

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> | c. LENGTH OF STAY IN lb <i>5 yrs</i> | b. COUNTY <i>Montgomery</i> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>8662 Piney Branch Rd - Apt 303</i> | | d. STREET ADDRESS <i>8662 Piney Br. Rd. Apt. 303</i> | |
| 3. NAME OF DECEASED (Type or print) <i>Col. Edward Herbert Hale</i> | First <i>Col.</i> | Middle <i>Edward</i> | Last <i>Herbert Hale</i> |
| 4. DATE OF DEATH <i>5-17-73</i> | Month <i>May</i> | Day <i>17</i> | Year <i>1959</i> |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <i>7-7-01</i> |
| 9. AGE (In years last birthday) <i>58 yrs.</i> | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Col. U.S.A. retired</i> | | 10b. KIND OF BUSINESS OR INDUSTRY |
| 11. BIRTHPLACE (State or foreign country) <i>S. D.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>A.S.A.</i> | |
| 13. FATHER'S NAME <i>Charles Hale</i> | | 14. MOTHER'S MAIDEN NAME <i>Lulu Harte</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> | | 16. SOCIAL SECURITY NO. <i>450-26-6958</i> | |
| 17. INFORMANT <i>Lt. Col. Leland Hale, 650 Coronado Ave.</i> | | Address <i>Coronado, California</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Congestive heart failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>[Blank]</i> DUE TO (c) <i>[Blank]</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <i>Frank J. Boschart</i> | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <i>11-7-59</i> |
| EXAMINER'S NAME (Type) <i>FRANK J. Boschart</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 11/12/59 | 22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NATIONAL CEMETERY | 22d. LOCATION (City, town, or county) ARLINGTON, VIRGINIA |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Zeska</i> | ADDRESS <i>SILVER SPRING, MD</i> | 24a. REC'D BY REGISTRAR NOV 10 '59 | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Times</i> |
| VS. AISM/E(S) 5M 9/55 | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12724

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by you, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

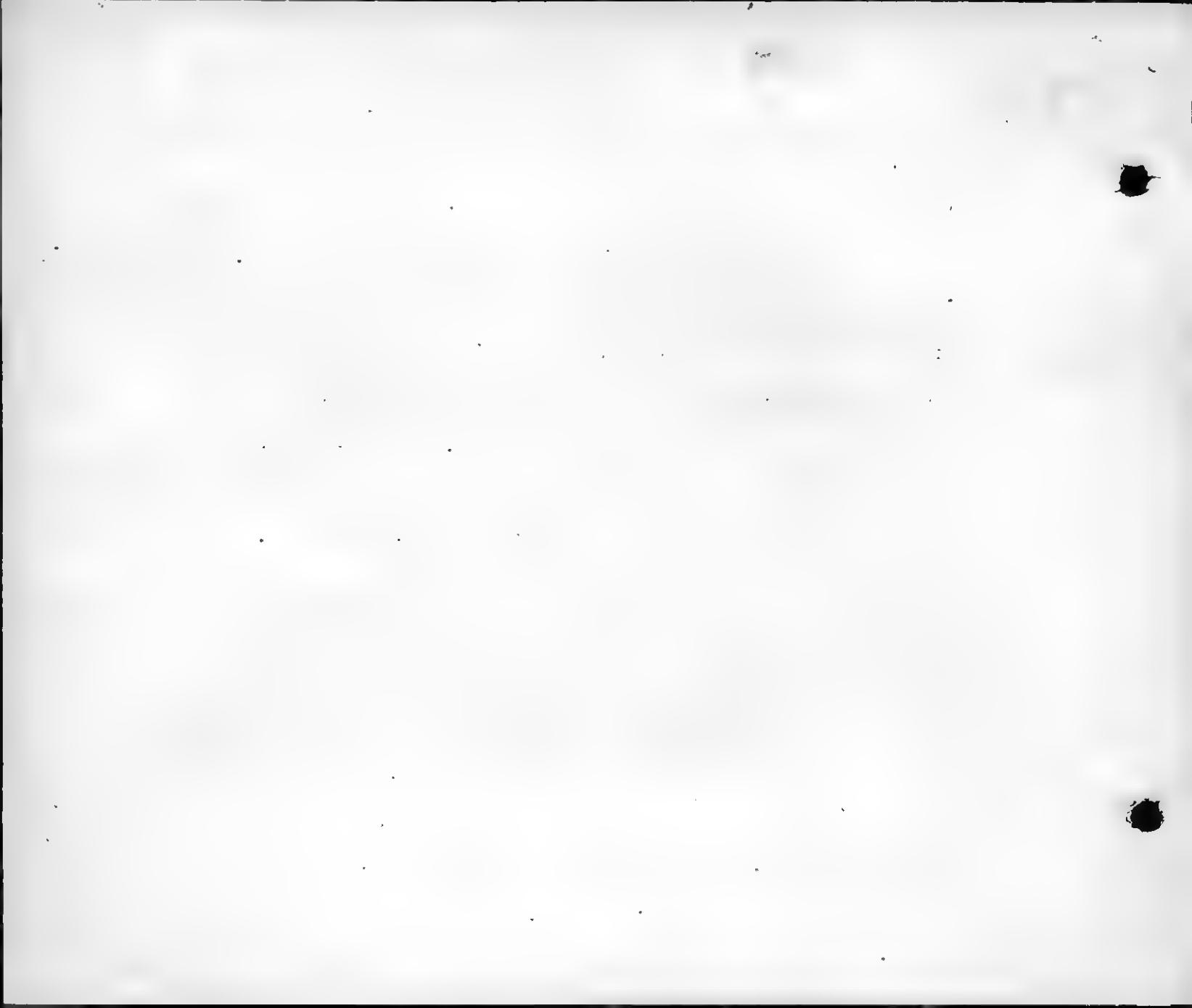
| | | | | | |
|--|--|---|---------------------|--|---|
| 1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>District of Columbia</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oney</i> | | c. LENGTH OF STAY IN 1b <i>1 month</i> | | b. COUNTY | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Chronic Hosp.</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i> | | d. STREET ADDRESS <i>1518 Webster St. N.W.</i> | |
| 3. NAME OF DECEASED (Type or print) <i>Ruth</i> | | First <i>Ruth</i> | Middle <i>C.</i> | Last <i>Hall</i> | 4. DATE OF DEATH <i>NOV. 1 1959</i> |
| 5. SEX <i>Female</i> | | 6. COLOR OR RACE <i>White</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>JULY 1, 1891</i> |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>House Wife</i> | | 11. BIRTHPLACE (State or foreign country) <i>Athwood, Tenn - U.S.A.</i> | |
| 13. FATHER'S NAME <i>Robert Yancy Carter</i> | | 14. MOTHER'S MAIDEN NAME <i>Louisa Harwood</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or date of service) <i>NO</i> | | 16. SOCIAL SECURITY NO <i>—</i> | | 17. INFORMANT <i>Pt's Admission Record</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>coronary occlusion</i> DUE TO <i>400.0</i> | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic heart disease</i> DUE TO <i>—</i> (c) <i>—</i> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>factory, street, office bldg., etc.</i> 20f. (City or town) (County) (State) <i>OLNEY, MD</i> | |
| 21. I certify that I attended the deceased from <i>Oct. 31, 1959</i> to <i>Nov. 1, 1959</i> , that I last saw the deceased alive on <i>Oct. 31, 1959</i> , and that death occurred at <i>1:30 P.M.</i> from the causes and on the date stated above. | | | | | |
| ADDRESS (Street, city or town, state) <i>OLNEY, MD</i> DATE SIGNED <i>Nov. 1, 1959</i> | | | | | |
| ACTUAL SIGNATURE <i>Lillian Ziegler M.D.</i> | | | | | |
| PHYSICIAN'S NAME (Type) <i>Lillian Ziegler M.D.</i> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 22b. DATE THEREOF <i>11-4-59</i> | | 22c. NAME OF CEMETERY OR CREMATORIUM <i>ARLINGTON NAT. CEM.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>MARTIN W. HYSONG COMPANY</i> | | ADDRESS <i>1300 N. STREET, N.W. - WASH. D.C.</i> | | 24a. REC'D BY REGISTRAR <i>NOV 2 '59</i> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <i>John S. Evans</i> | |



1.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | | | 12725 | | | | |
|--|--|--------------------------------------|---|--|-----------------------|---|---|--|---|-----------|--------------------------------------|---|--|--|--------------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | Reg. Dist. No. | | | | |
| 1. PLACE OF DEATH a. COUNTY Montgomery | | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8505 Hazelwood Drive | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | First MARY | Middle ALICE | Last HALLER | 4. DATE OF DEATH Nov. 25 1959 | | | Month Nov. | Day 25 | Year 1959 | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/19/1883 | | | 9. AGE (In years last birthday) 70 yrs. | | 10. IF UNDER 1 YEAR 5 Months | | 11. IF UNDER 24 HRS 8 Days | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | | | 11. BIRTHPLACE (State or foreign country) Ohio | | | | 12. CITIZEN OF WHAT COUNTRY? US | | | | |
| 13. FATHER'S NAME Joseph Steinhouer | | | | | | 14. MOTHER'S MAIDEN NAME Margaret Davis | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | 16. SOCIAL SECURITY NO. None | | | INFORMANT Elden D. Haller-son-same as 2d | | | Address | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acidosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) diabetes mellitus & delayed action DUE TO (c) romoly | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 days 2 yrs | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis C-V. disease | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Artosclerosis C-V. disease | | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 2/20, 1956 , to 11/25, 1957 , that I last saw the deceased alive on 11/25, 1957 , and that death occurred at 7:30 AM , from the causes and on the date stated above. | | | | | | | | | | | | ADDRESS (Street, city or town, state) Rockville, Maryland | | | | |
| ACTUAL SIGNATURE <i>Stephen N. Jones</i> | | M.D. | | DATE SIGNED 11/25/57 | | | | | | | | | | | | |
| PHYSICIAN'S NAME (Type) Stephen N. Jones | | Rockville, Maryland | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 11/25/59 | | 22b. DATE THEREOF 11/25/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Sunset Cemetery | | 22d. LOCATION (City, town, or county) Columbus, Ohio | | (State) | | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Maryland | | 24a. REC'D BY REGISTRAR NOV 27 '59 | | 24b. REGISTRAR'S SIGNATURE <i>Charles H. ...</i> | | | | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 File # 53 12-15-59 et

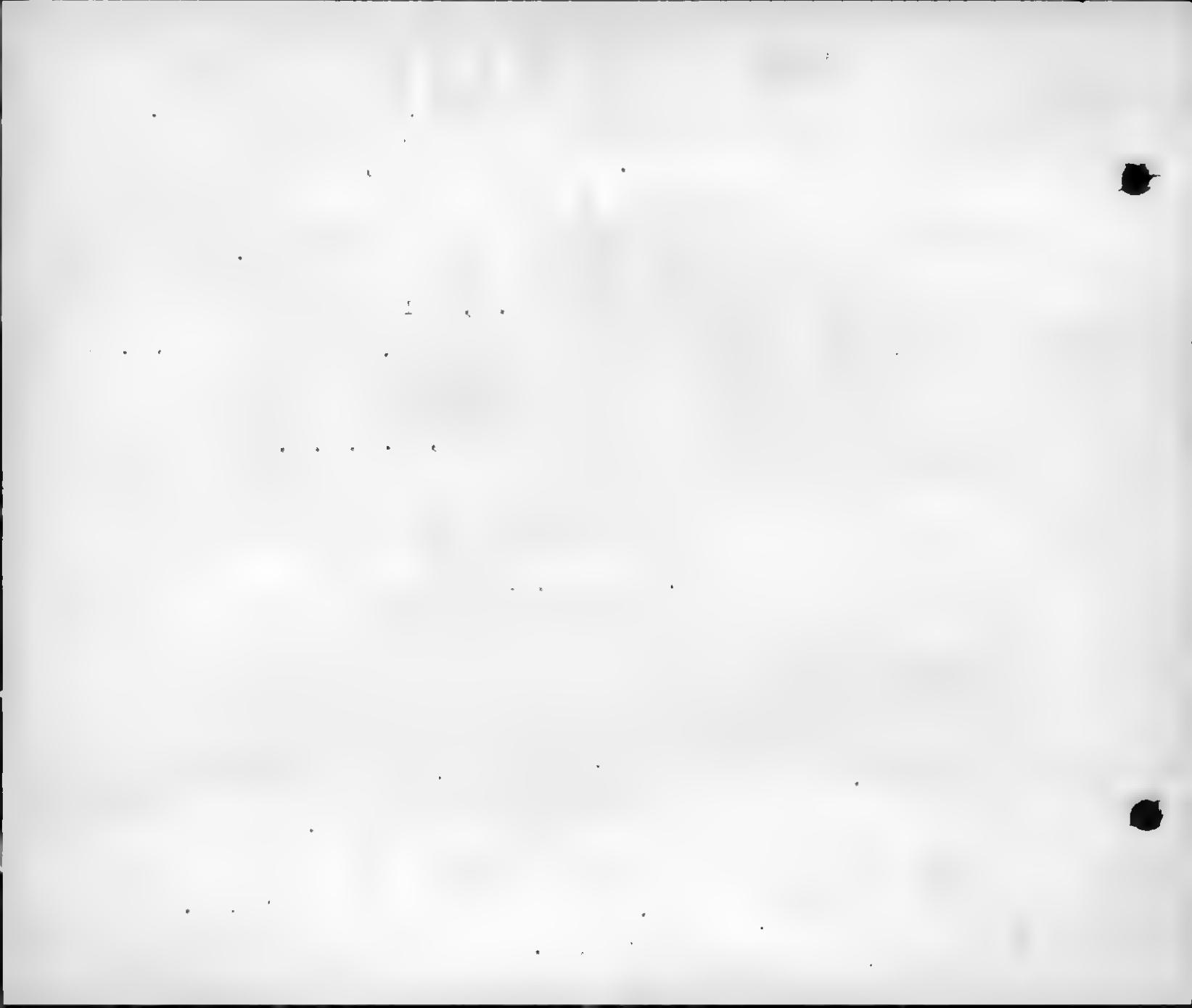
12726

12759

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|------------------------------|---|---|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Montg. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck | | c. LENGTH OF STAY IN 1b 3 Yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville, | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bradford Rest Home | | | | d. STREET ADDRESS | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First Charles | Middle Hamilton | 4. DATE OF DEATH | Month Nov. | Day 21 | Year 1959 |
| 5. SEX male | 6. COLOR OR RACE O | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 1, 1891 | 9. AGE (In years last birthday) 68 yrs | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Days 0 | 12. Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) Maryland. | | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME James Hamilton | | | | 14. MOTHER'S MAIDEN NAME Mary White | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 17. INFORMANT Dickerson, Md. R. F. D. | | | |
| Address | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Infection; Anuria Indwelling Catheter INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 442 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Hemiplegia; Paraphymosis; (c) Hypertensive C.R. Disease | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Norbeck | (County) Rt. 1 | (State) Md. |
| 21. I certify that I attended the deceased from Oct. 18, 1959 to Nov. 21, 1959 , that I last saw the deceased alive on Nov. 18, 1959 , and that death occurred at 5:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Norbeck Rt. 1 DATE SIGNED 11/23/59 | | | | | | | |
| ACTUAL SIGNATURE <i>Webster Sewell</i> | | | | | | | |
| PHYSICIAN'S NAME (Type) Webster Sewell Silver Spring, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/26/59 | 22c. NAME OF CEMETERY OR CREMATORIUM Mt. Zion, | | 22d. LOCATION (City, town, or county) Barnesville, Md. (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Swanson</i> | | | | ADDRESS Rockville, Md. | | 24a. REC'D BY REGISTRAR DATE NOV 30 '59 | 24b. REGISTRAR'S SIGNATURE <i>C. J. Lewis & Son</i> |



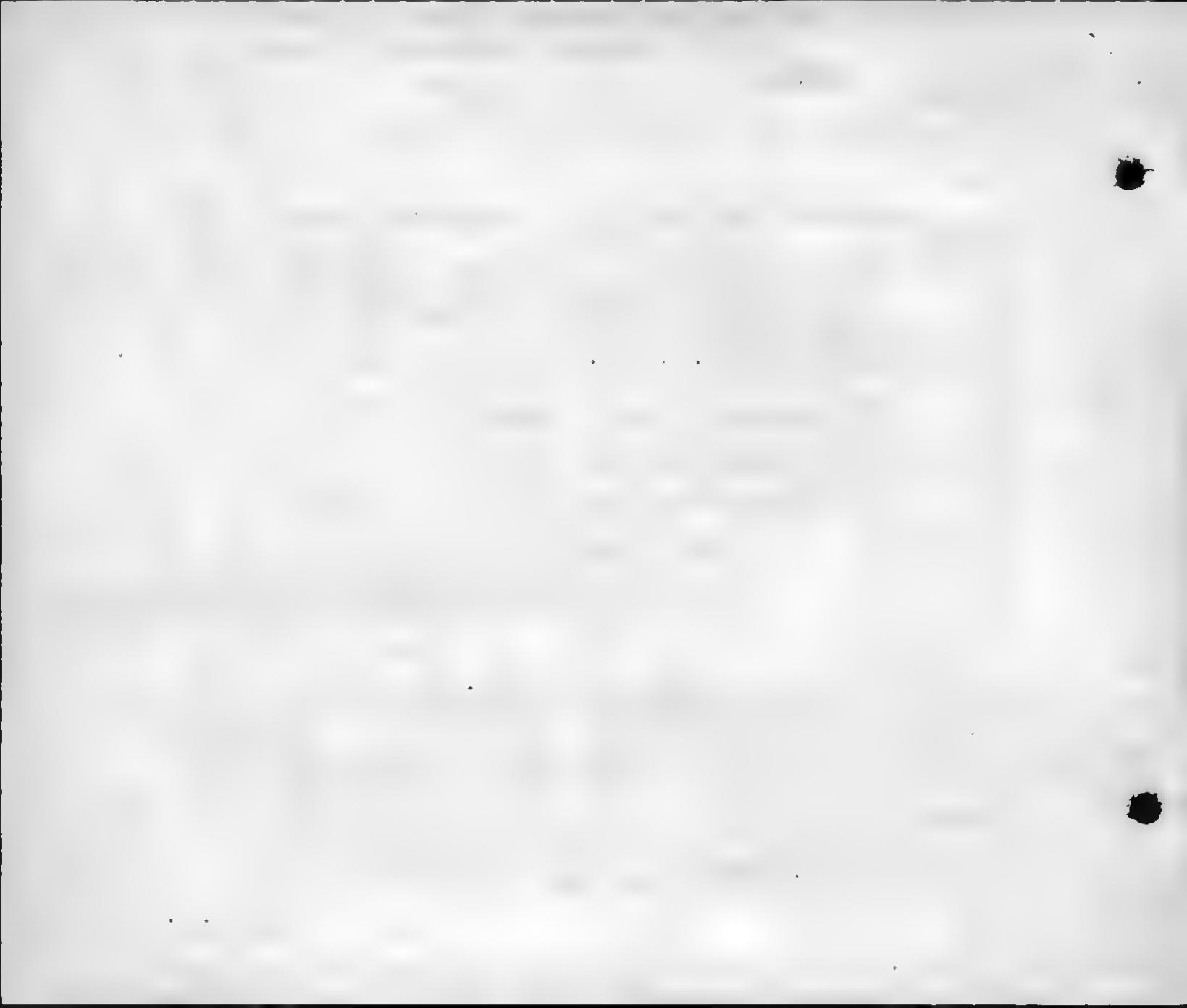
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12727

Reg. Dist. No.

| | | | | | | | | | | | |
|--|--|---|---------|---|------------------|---|-----|--|-----------------------|--|--|
| 12760 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Montgomery County MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase | | d. STREET ADDRESS 116 Grafton Street | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) National Institutes of Health | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Lillian | | First | Middle | Last | 4. DATE OF DEATH | Month | Day | Year | | | |
| | | R. | Hancock | | November | 30 | | 1959 | | | |
| 5. SEX F | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 18, 1986 | | 9. AGE (In years last birthday) 73 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10c. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired office worker | | | | 10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt. | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Carlin Stan | | | | 14. MOTHER'S MAIDEN NAME Annie Roberts | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Hospital records | | Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hematoma | | | | | | | | | | | |
| 902.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fall from bed | | | | | | | | | | | |
| | | | | | | | | | | | |
| DUE TO (c) | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Leukemia | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from bed in hospital | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 11 11 59 PMX | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital | | 20f. (City or town) Bethesda | | (County) Montg. | (State) Md. | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | |
| | | DATE SIGNED 11/30/59 | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12/3/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Rock Creek Cemetery | | 22d. LOCATION (City, town, or county) Washington, D. C. | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland | | ADDRESS _____ | | 24a. REC'D BY REGISTRAR DATE DEC 2 '59 | | 24b. REGISTRAR'S SIGNATURE C. H. S. K. | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

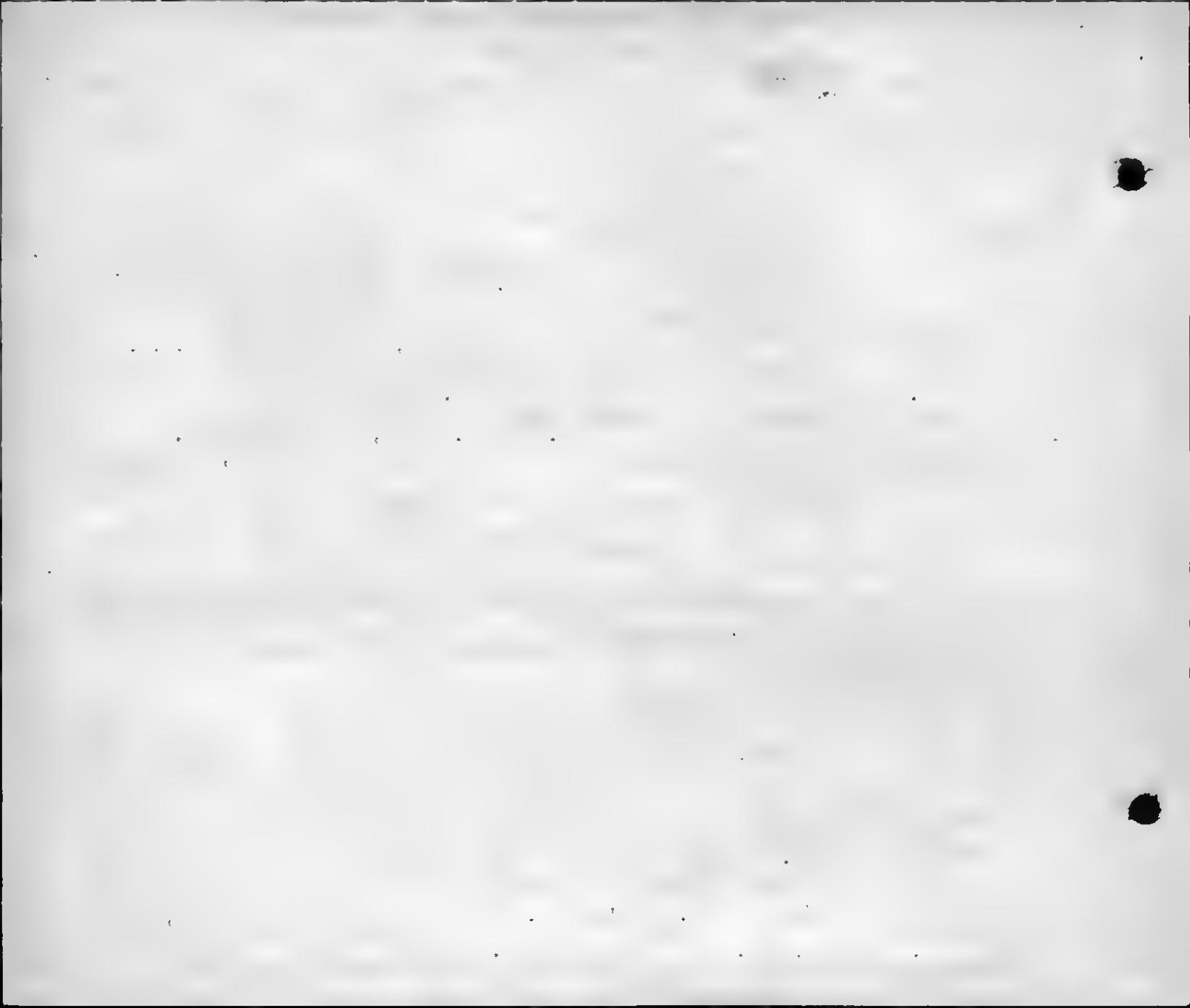
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item Id. File # 12728

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|-----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND | |
| MONTGOMERY MARYLAND | | b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | c. LENGTH OF STAY IN 1b 3 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ABERDEEN | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10605 Dunkirk Drive Private home of deceased | | d. STREET ADDRESS 109 Rigdon Road | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First SUSANNA | Middle SCOTT | Last Hardy |
| 4. DATE OF DEATH | Month NOV. | Day 29 | Year 1959 |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH 8/3/82 |
| 9. AGE (in years from birth) 77 yrs | | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS. Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME JOHN H. Surratt | | 14. MOTHER'S MAIDEN NAME MARY E. HUNTER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO NONE | |
| 17. INFORMANT Mr. John H. Hardy, 7200 Hilton Ave., Takoma Park, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Cerebral sclerosis (c) | | INTERVAL BETWEEN ONSET AND DEATH 10 min. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pleurisy & pneumonia, rt lung | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour o. m. p. m. | Month 19 | 20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Nov. 27, 1959, to Nov. 29, 1959, that I last saw the deceased alive on Nov. 27, 1959, and that death occurred at 10620 1/2 Ave., M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Philip H. Warner, M.D. 10620 1/2 Ave., Silver Spring, Md. DATE SIGNED 11-29-59 | | | |
| ACTUAL SIGNATURE | PHYSICIAN'S NAME (Type) | | |
| PHILIP H. VARNER | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 12/2/59 | 22c. NAME OF CEMETERY OR CREMATORIUM ST. JOHN'S CATH. CEMETERY | 22d. LOCATION (City, town, or county) MONTGOMERY COUNTY, MARYLAND (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. BUMPHREY, INC. Edmund L. Warner | | ADDRESS SILVER SPRING, MD. | 24a. REC'D BY REGISTRAR DATE DEC 1 '59 |
| | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Krause |



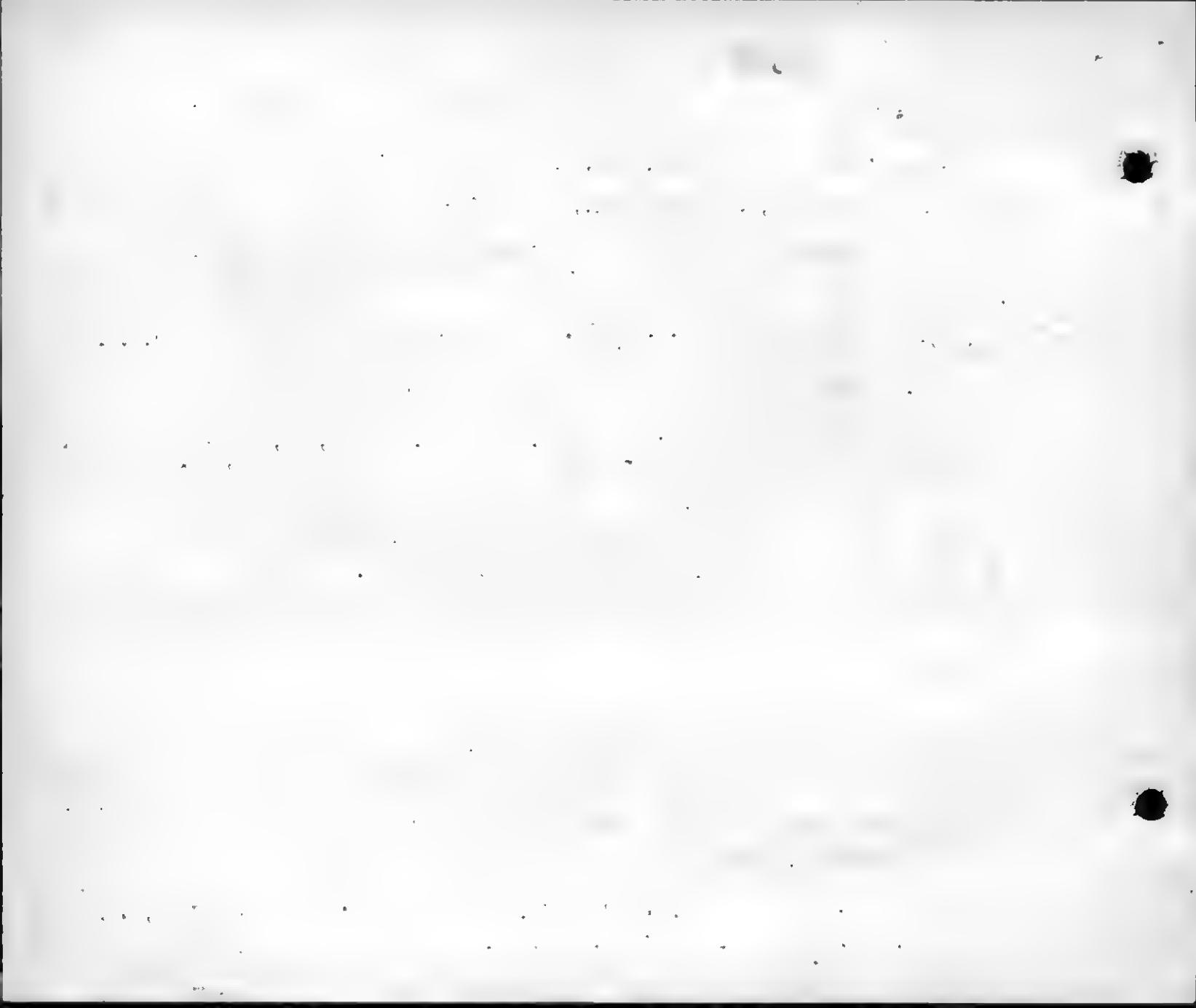
12723

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. _____

| | | | | |
|---|-------------------------------------|---|--|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK | | c. LENGTH OF STAY IN 1b since Apr. 1959 | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EVENTITE NURSING HOME, 700 HUDSON AVE., | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | |
| f. STREET ADDRESS 741 SLIGO AVENUE | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | First Juliet | Middle A | Last Harper | |
| 4. DATE OF DEATH | | | Month NOVEMBER 5 | Day 1959 |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/17/73 | 9. AGE (In years last birthday) 85 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (Bureau of Printing & Engraving) | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T. | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME George A. Harper | | 14. MOTHER'S MAIDEN NAME Mary Hopkins | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. none | INFORMANT Mrs. Walter D. Gilson, 11,605 Maple View Dr. | Address Silver Spring, Md. |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which give rise to immediate cause (a), stating the under- lying cause last. } (b) DUE TO } (c) <i>Sensibility</i> <i>Atherosclerosis, generalized</i> <i>Arterosclerotic Heart Disease</i> | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from April , 19 59 , to Nov , 19 59 , that I last saw the deceased alive on Nov. 3 , 19 59 , and that death occurred at 1:15 P.M. from the causes and on the date stated above. | | | | |
| ADDRESS (Street, city or town, state) 217 University Blvd E. DATE SIGNED 11-5-59 | | | | |
| ACTUAL SIGNATURE <i>Bernard A. Fitzgerald</i> | | | | |
| PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD | | | | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 11/9/59 | 22c. NAME OF CEMETERY OR CREMATORIUM ST. JOHN'S CATH. CEMETERY | 22d. LOCATION (City, town, or county) MONTGOMERY COUNTY, MD. | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Ziska</i> | | ADDRESS SILVER SPRING, MD. | 24a. REC'D BY REGISTRAR DATE NOV 10 '59 | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Traus</i> |



TO HOSPITAL OR ENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

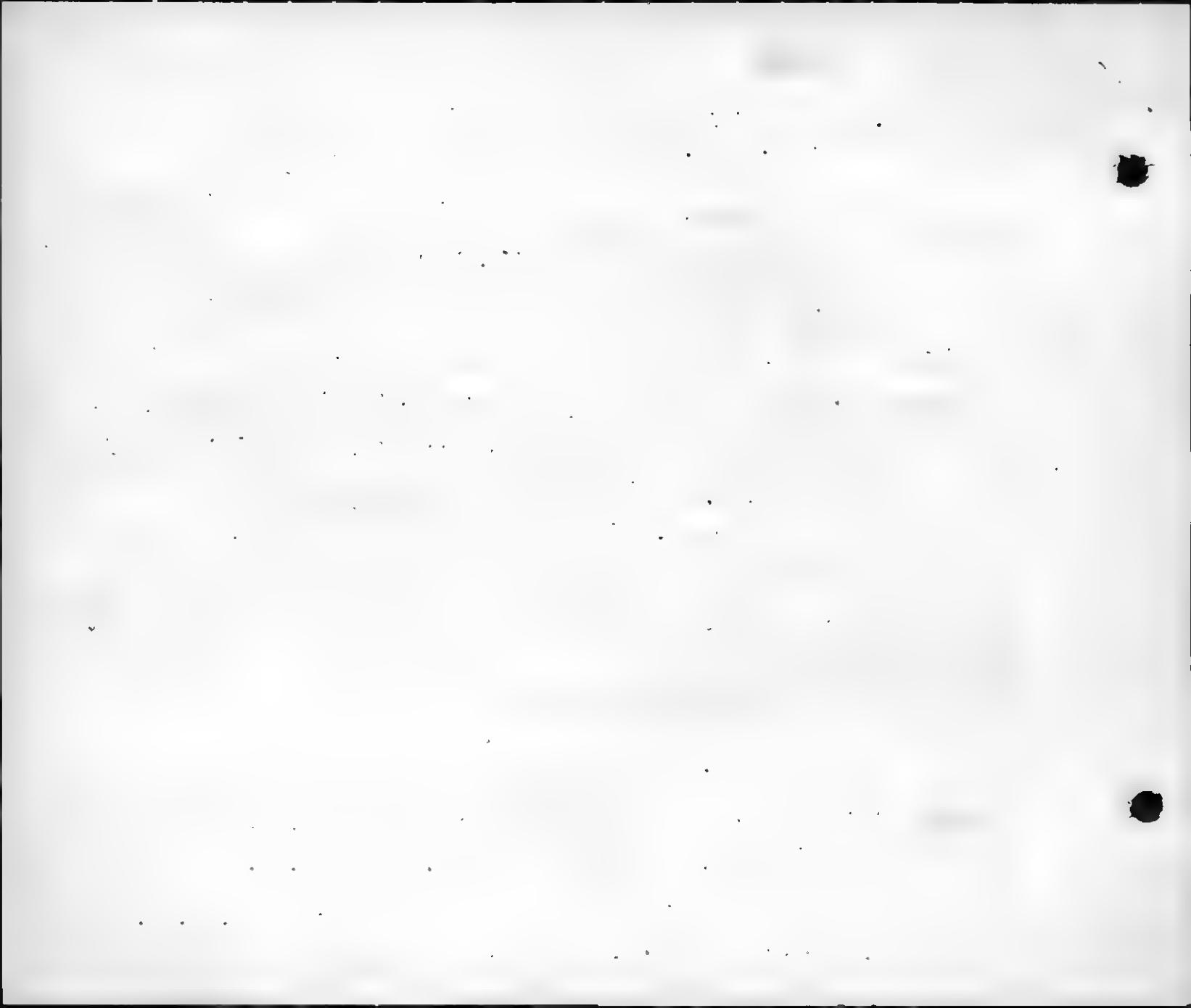
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12762

CERTIFICATE OF DEATH

Reg. Dist. No. 12730

| | | | | | | | | |
|--|--|---|---|---|---------------------------------|--|--|------|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | | | | | |
| Montgomery | | D.C. | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b RURAL and give nearest town | | | | | | |
| Bethesda 20 hrs | | Washington 41 1/2 | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| Suburbas | | 3621 Newark St. N.W. | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle | Last | 4. DATE OF DEATH | Month | Day | Year |
| Ann W. | | R | Harter | 11 | 22 | 1959 | | |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | B. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS. Days Hours Min | |
| F | | W. | | 11-27-91 | 67 yrs | 11 25 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Home maker | | — | | Pennsylvania | | U.S.A. | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 15. INFORMANT | | Address | | |
| James Ross | | Elizabeth Seacrest | | Dr. R.P. Harter - Son Wash. | | 4953 Brodhead | | |
| 16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 17. SOCIAL SECURITY NO. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Esophageal small bowel & ascending colon</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Mesenteric venous thrombosis</i> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 24 hours | | |
| | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) | | | DATE SIGNED 11/22/59 | | | |
| ACTUAL SIGNATURE <i>Karl Dortschak</i> | | M.D. 5123 Tilden N. W. | | | | | | |
| PHYSICIAN'S NAME (Type) Karl Dortschak M.D. | | Washington, D. C. | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/25/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Rock Creek Cemetery | | 22d. LOCATION (City, town, or county) Washington, D. C. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Maryland | | 24a. REC'D BY REGISTRAR DATE NOV 25 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12731

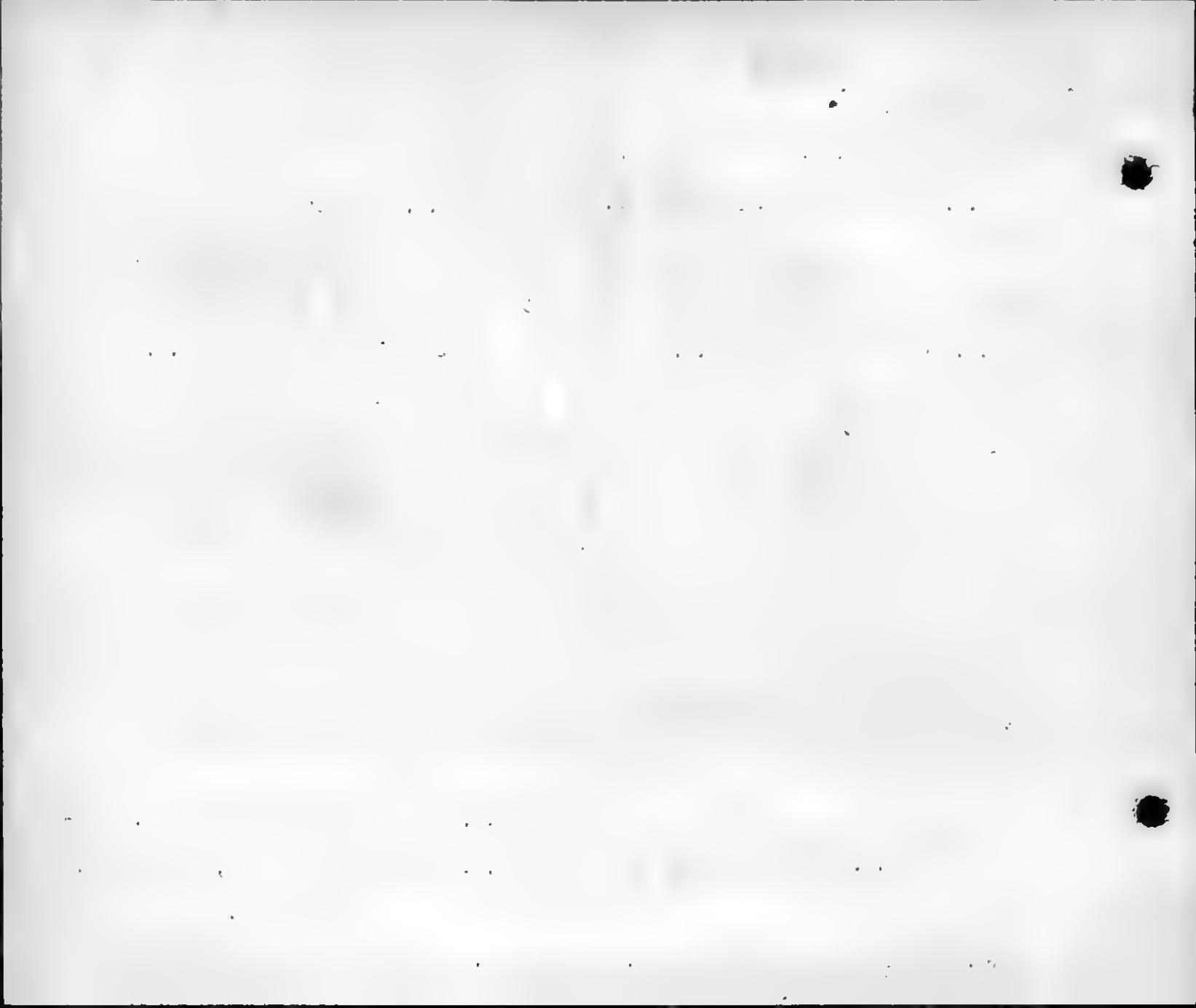
12763

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | | |
|--|--|---|---|---|---|---|
| 1 PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Florida | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 56 days | | d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Homestead | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md. | | e. STREET ADDRESS 1725 N.W. 8th Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | First Albert | Middle Rossville | Last HECKEY | 4. DATE OF DEATH Month November | Day 4 | Year 19 59 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-2-04 | 9. AGE (In years last birthday) 55 yrs. | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Government | | 10c. BIRTHPLACE (State or foreign country) Colorado | | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13. FATHER'S NAME Rossville Hekey | | | 14. MOTHER'S MAIDEN NAME Elizabeth Marah | | | Address |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. WW II | | INFORMANT (Wife) Casta Hekey | | 17. INTERVAL BETWEEN ONSET AND DEATH 1 yrs. |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Esophagus & Intestines</i> DUE TO 150x Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part or Part II of item 18) | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | Month 19 | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that I attended the deceased from 9 September 19 59 to 4 November 19 59 at U.S. Naval Hospital, Bethesda Md. and that death occurred at 1:20P M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>David P. Osborne</i> ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) D.P. OSBORNE CAPT MC USN DATE SIGNED 11-5-59 | | | | | | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) Burial | 22b. DATE THEREOF 11-6-59 | 22c. NAME OF CEMETERY OR CREMATORIAL Arlington National | 22d. LOCATION (City, town, or county) Arlington Va. | | | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Reverend John J. Murphy</i> | ADDRESS 1157 Wisconsin Ave. Bethesda Md. | 24a. REC'D BY REGISTRAR DATE NOV 10 '59 | | 24b. REGISTRAR'S SIGNATURE <i>Charles S. Evans</i> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



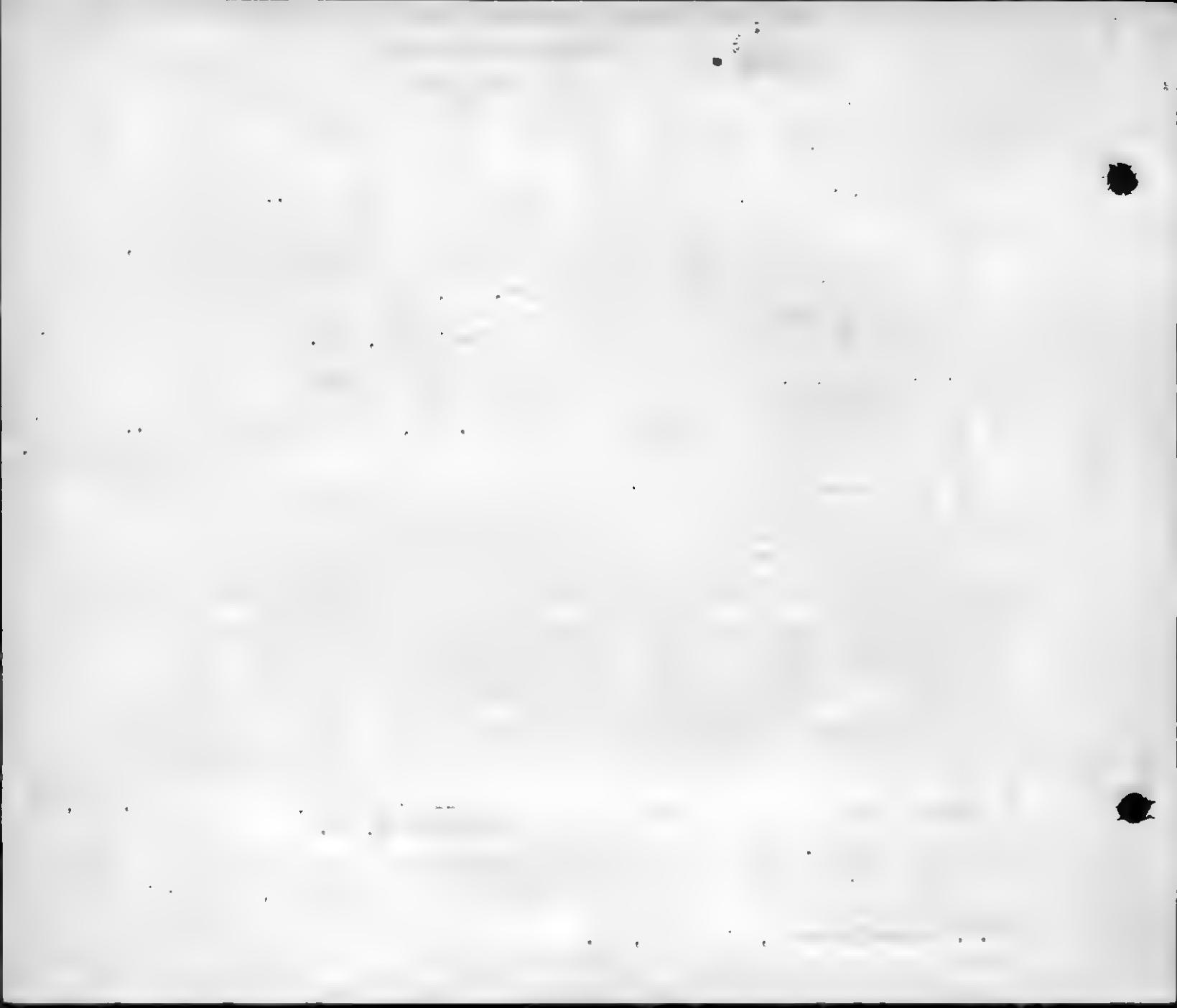
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12764 . CERTIFICATE OF DEATH

Reg. Dist. No. 12732

| | | | | | | | | | |
|---|----------------------------------|--|---|---|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Silver Spring | | c. LENGTH OF STAY IN 1b 9 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville | | d. STREET ADDRESS 4821 Rhode Island Ave., | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fairland Nursing Home, Fairland Road | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | First FRANCES | Middle HAYNES | Last ANDREWS | 4. DATE OF DEATH November 28th, 1959 | Month November | Day 28th | Year 1959 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 2nd, 1868 | | 9. AGE (In years last birthday) 91 | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Days 0 | 12. IF UNDER 24 HRS Hours 0 | 13. IF UNDER 24 HRS Min 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY At home | | 11. BIRTHPLACE (State or foreign country) Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME William Andrews | | | | 14. MOTHER'S MAIDEN NAME (Unknown) Jones | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Elnora V. Day, 4821 Rhode Island Ave., Hyattsville | | Address 141 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x | | DUE TO Central Thrombosis - right | | | | INTERVAL BETWEEN ONSET AND DEATH 8 hrs | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first Renalized artery & lysis | | (b) DUE TO 20 yrs | | | | | | | |
| (c) | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 12-7 - 1956 to 11-28 1959 , that I last saw the deceased alive on 11-28 1959 , and that death occurred at 11:30 P.M. from the causes and on the date stated above. | | | | | | ADDRESS (Street, city or town, state) | | DATE SIGNED Nov. 30th, 1959 | |
| ACTUAL SIGNATURE John P. Clum | | M.D. 6110--43rd Avenue, Hyattsville, Md. | | | | | | | |
| PHYSICIAN'S NAME (Type) John P. Clum | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12/1/1959 | | 22c. NAME OF CEMETERY OR CREMATORIUM Mount View Mausoleum | | 22d. LOCATION (City, town, or county) Pasadena, California | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md. | | ADDRESS | | | | 24a. REC'D BY REGISTRAR DATE DEC 1 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Krause | |



TO HOSPITAL OR The law requires that the death certificate be executed within 24 hours after death. Page 4
TO ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician and completely filled in by the funeral director.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

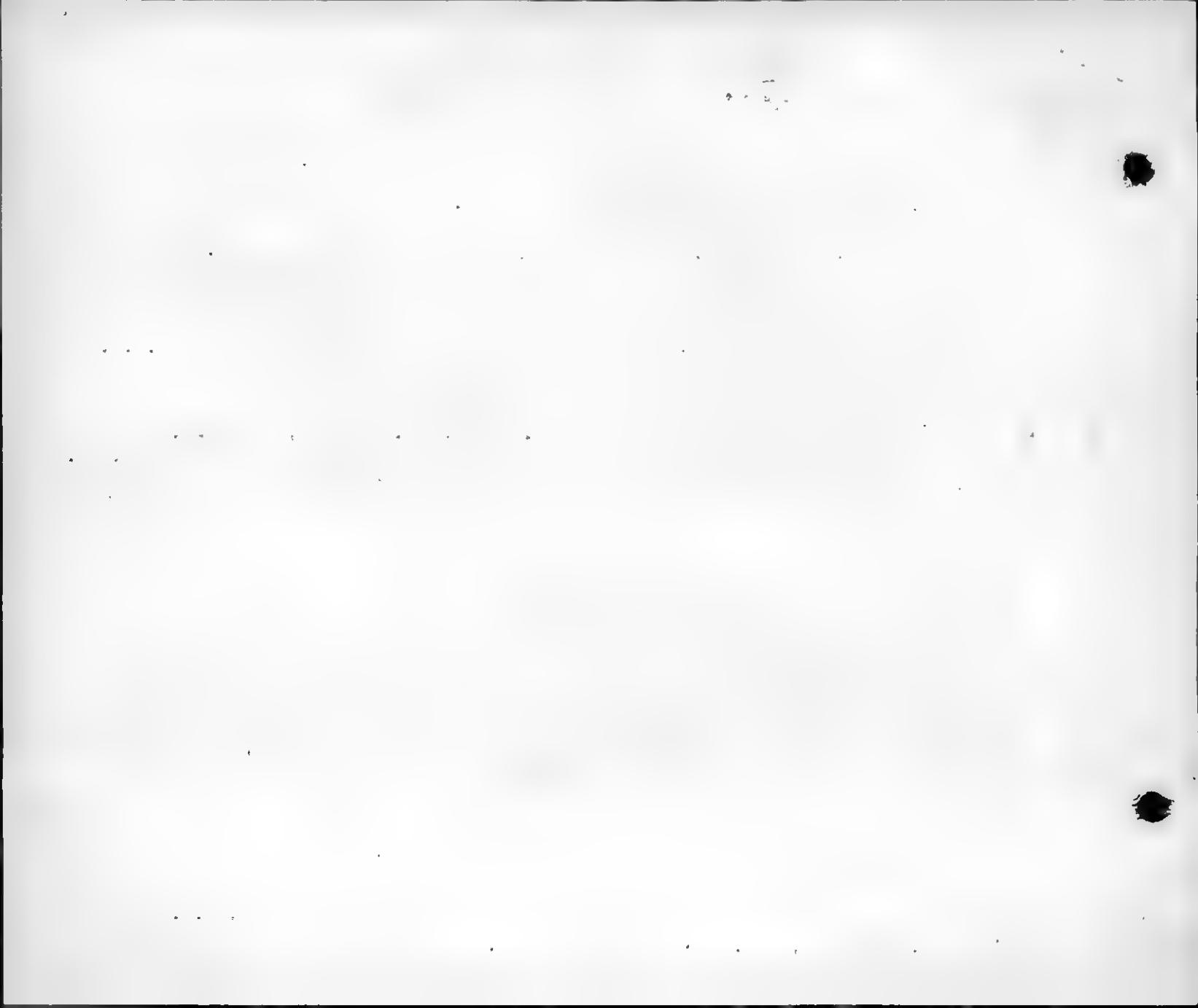
12765

CERTIFICATE OF DEATH

12765

Reg. Dist. No.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | c. LENGTH OF STAY IN lb 3 months | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Althea-Woodland Nursing Home | d STREET ADDRESS 203 E. Hamilton Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) Laura Marie Hickman | First | Middle | Last |
| 4. DATE OF DEATH Month NOV. Day 26 Year 1959 | Month | Day | Year |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/23/76 |
| 9. AGE (In years last birthday) 83 yrs. | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS. Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | |
| 11. BIRTHPLACE (State or foreign country) VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WILLIAM DAVIS | | 14. MOTHER'S MAIDEN NAME ROSE BROWN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. INFORMANT Mrs. Ludwell F. Catlett, 9307 Walden Road Address Silver Spring, Md. | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X | | INTERVAL BETWEEN ONSET AND DEATH 6 mos | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) | | DUE TO Congestive heart failure | |
| (c) | | DUE TO Hypertension | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) | | 18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 1958 , 19, to Nov 26 , 1959, that I last saw the deceased alive on Nov 24 , 1959, and that death occurred at _____ M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 13018 GEORGIA AVE | | DATE SIGNED 11/26/59 | |
| ACTUAL SIGNATURE A. W. Smith | | PHYSICIAN'S NAME (Type) A. W. SMITH | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 11/28/59 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM GLENWOOD CEMETERY | | 22d. LOCATION (City, town, or county) WASHINGTON, D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. | | 24a. REC'D BY REGISTRAR DATE DEC 1 '59 | |
| VS A15 (4) 15M 9/58 | | 24b. REGISTRAR'S SIGNATURE Arthur J. Krause | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1. Film 254 11-10-59 ans

CERTIFICATE OF DEATH

Reg. Dist. No. 12734

| | | | | | | | | | | | | | |
|---|------------------|---|------------------|--|---|---|-------------------------------|---|-----------------------------|------------|--|---|--|
| 32766 | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY | | MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | | | | | |
| Montgomery | | MARYLAND | | | | a. STATE New Jersey | | b. COUNTY | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | | | |
| Bethesda | | 41 days | | | | Atlantic City | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | The Clinical Center, Bethesda 14, Md. | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| First Herbert | | Middle Farley | Last Hilliard | 4. DATE OF DEATH | | Month November | | Day 18 | | Year 19 59 | | | |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH | | 9. AGE (In years lost birthday) 1 yrs | | 10. IF UNDER 1 YEAR Months | | 11. IF UNDER 24 HRS Days | | | | |
| Male | Negro | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | December 3, 1957 | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | | | | | |
| None | | None | | North Carolina | | U. S. A. | | | | | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| Herbert L. Hilliard | | Justine Wilkins | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | The Medical Record Address | | | | | | | |
| no | | None | | Pericardial or Gastro-intestinal Hemorrhage. | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <input checked="" type="checkbox"/> Central Nervous System or Hemorrhage | | INTERVAL BETWEEN ONSET AND DEATH hours | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | DUE TO | | | | | | | | | | | |
| 173.4 | | Pericardial or Gastro-intestinal Hemorrhage. | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) | | Neuroblastoma with Metastases | | | | | | | | | | | |
| (c) | | DUE TO | | | | | | | | | | | |
| 6 Months | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner.) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | | |
| 19 | | | | | | | | | | | | | |
| 21. I certify that I attended the deceased from October 8, 1959, to November 18, 1959, that I last saw the deceased alive on November 18, 1959, and that death occurred at 6:01 P.M., from the causes and on the date stated above. | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | M.D. | | The Clinical Center | | ADDRESS (Street, city or town, state) | | DATE SIGNED | | | | | |
| HAROLD J. FALLON | | | | | | National Institutes of Health | | 11-19-59 | | | | | |
| PHYSICIAN'S NAME (Type) | | | | | | Bethesda 14, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORIAL | | 22d. LOCATION (City, town, or county) | | (State) | | | | | |
| 11-20-59 | | | | | | Rocky Mount, N.C. | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | | PC | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | | | | | |
| Frazier's Funeral Home, Inc. | | 389 R.D. Ave. N.W. | | | | | | Cathleen S. Kuhn | | | | | |
| | | | | | | | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12735

12767

CERTIFICATE OF DEATH

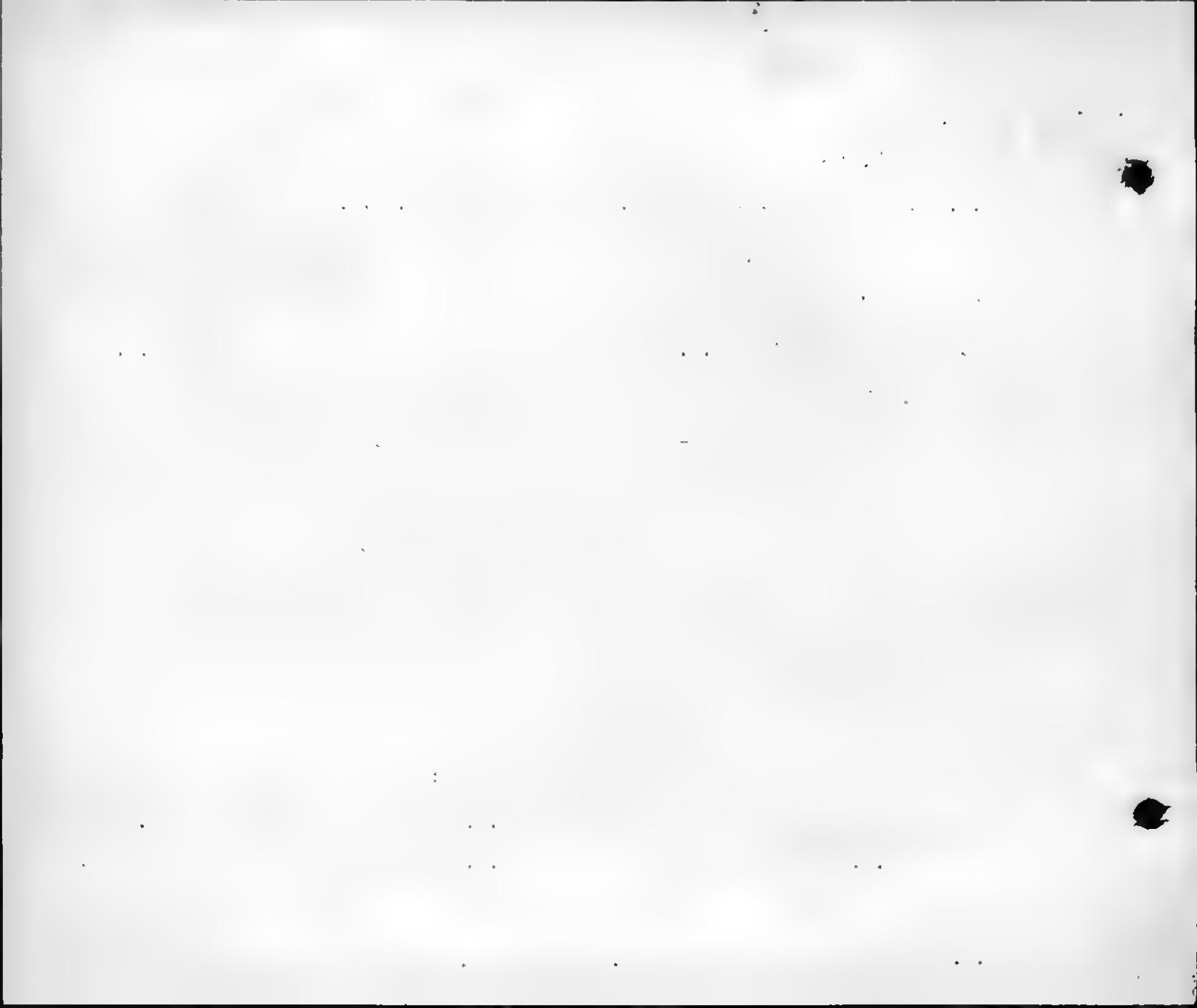
Reg. Dist. No. 215

TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

| | | | | | | | | |
|--|---|---|---|--|---|--|--------------------|---------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE District of Columbia | | b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN lb 13 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | d. STREET ADDRESS 2300 Conn. Ave. | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) VICTOR | | First (n) | Middle | Last HOLDEN | 4. DATE OF DEATH November 27 1959 | Month November | Day 27 | Year 1959 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH 5-24-99 | 9. AGE (In years last birthday) 60 yrs. | IF UNDER 1 YEAR Months 00 | IF UNDER 24 HRS Days 00 | Hours 00 | Min. 00 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreign Service Officer | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Government | 11. BIRTHPLACE (State or foreign country) Oklahoma | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | |
| 13. FATHER'S NAME James F. HOLDEN | | 14. MOTHER'S MAIDEN NAME Charlotte ELSWORTH | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO 106-07-2794 | | INFORMANT (Wife) Myra Holden | Address Same as #2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis, Liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I attended the deceased from 14 November, 1959 , to 27 November, 1959 that I last saw the deceased alive on 27 November, 1959 , and that death occurred at 5:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>John L. Beeby</i> M.D. U.S. Naval Hospital, Bethesda Md. 11-28-59 | | | | | | | | |
| PHYSICIAN'S NAME (Type) J.L. BEEBY LT MC USN | | U.S. Naval Hospital, NNMC, Bethesda Md. | | | | | | |
| 22a. BUR. A. CREMATION, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 11/30/59 | | 22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory | | 22d. LOCATION (City, town, or county) Prince George County | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>R.A. Pumphrey</i> | | ADDRESS 7551 Wisconsin Ave. Bethesda Md. | | 24a. REC'D BY REGISTRAR DATE DEC 2 '59 | | 24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i> | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12768

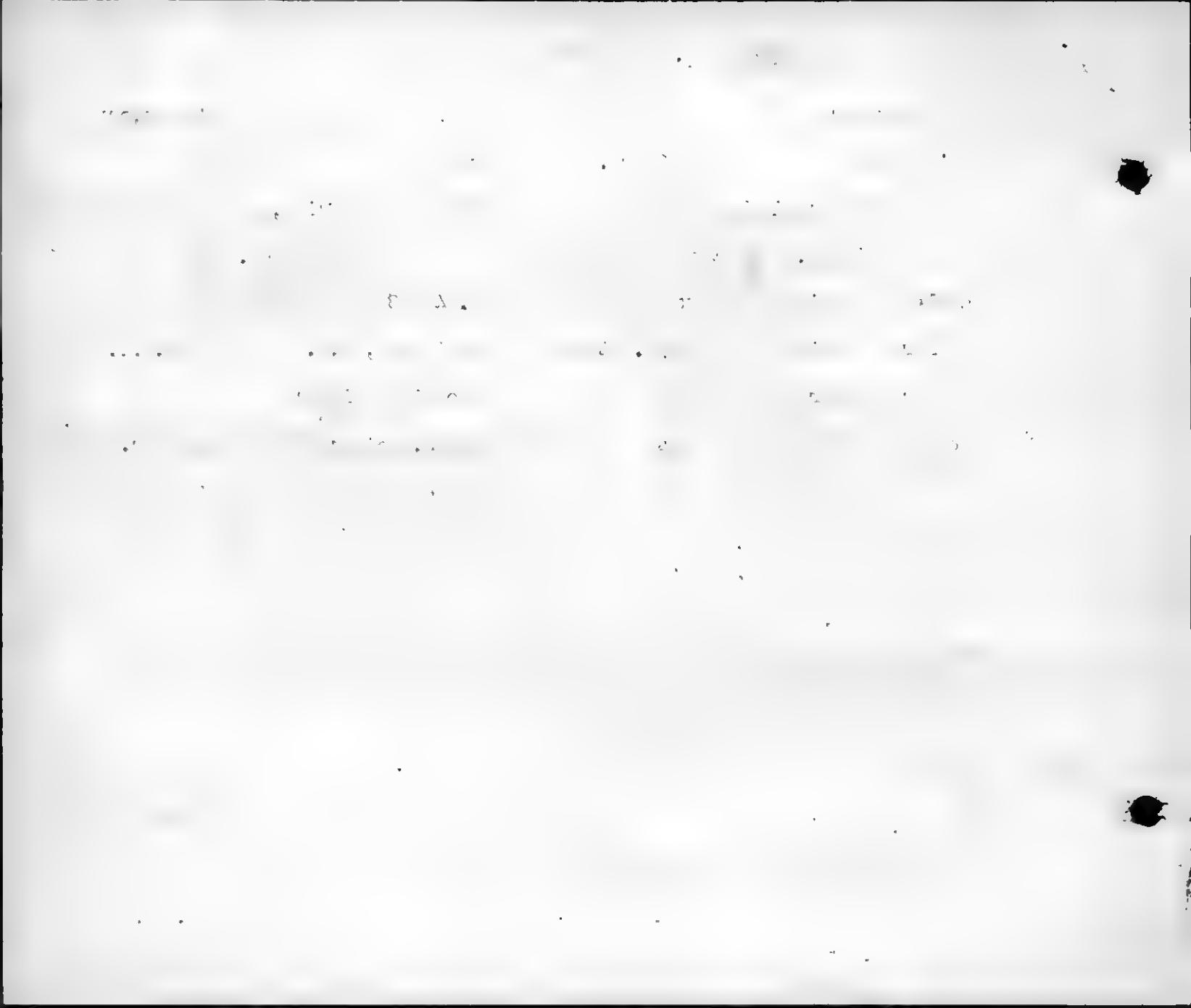
CERTIFICATE OF DEATH

12756

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 2 hrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital | | e. STREET ADDRESS 6005 Ryland Drive, | |
| 3. NAME OF DECEASED (Type or print) Edna A. Holloran | First | Middle | Last |
| 4. DATE OF DEATH Nov. 8 | Month | Day | Year 1959 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Feb. 4 1934 |
| 9. AGE (In years last birthday) 75 yrs. | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Days 0 | 12. IF UNDER 24 HRS Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (retired) | 10b. KIND OF BUSINESS OR INDUSTRY Dept. Store | 11. BIRTHPLACE (State or foreign country) Washington, D.C. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Conrad Eber | 14. MOTHER'S MAIDEN NAME Sophia Aigler | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. Yes | INFORMANT Margaret A. Holloran | Address 6005 Ryland Dr. Bethesda |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) ACUTE PULMONARY EDEMA ACUTE MYOCARDIAL INFARCTION CROHN'S ARTEROSCLEROSIS INTERVAL BETWEEN ONSET AND DEATH 2 HOURS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) HYPERTENSIVE CARDIOVASCULAR DISORDERS | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from March , 1955, to Nov. 8 , 1959, that I last saw the deceased alive on Nov. 8 , 1959, and that death occurred at 12 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Joseph D. Connor | M.D. Joseph D. Connor | ADDRESS (Street, city or town, state) 9420 60th Street, Bethesda, Maryland | |
| PHYSICIAN'S NAME (Type) JOSEPH D. CONNOR | DATE SIGNED Dec. 4, 1959 | | |
| 22a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial | 22b. DATE THEREOF 11/10/59 | 22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery | 22d. LOCATION (City, town, or county) Washington, D. C. (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | ADDRESS Bethesda, Maryland | 24a. REC'D BY REGISTRAR NOV 13 1959 | 24b. REGISTRAR'S SIGNATURE John & Krause |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12757

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | |
|--|----------------------------------|---|--|--|---|--|---|-------------------------------|------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>District of Columbia</i> | | b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BETHESDA</i> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington D.C.</i> | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Resmor Sanitorium Hospital</i> | | e. STREET ADDRESS <i>1210 E Capital St</i> | | f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <i>Isabel White</i> | | First | Middle | Last | DATE OF DEATH <i>Sept 7 - 1874</i> | Month | Day | Year | |
| S. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH <i>Sept 7 - 1874</i> | | 9. AGE (In years lost/birthday) <i>93 yrs.</i> | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | Hours | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Arizona</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | |
| 13. FATHER'S NAME <i>UNKNOWN</i> | | 14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT <i>RESMOR SANITORIUM RECORDS</i> | | Address | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>(b)</i> DUE TO <i>(c)</i> DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <i>2-3 days</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Renal failure</i> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) <i>Washington</i> | | (County) <i>D.C.</i> | (State) <i>D.C.</i> |
| 21. I certify that I attended the deceased from _____ to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, from the causes and on the date stated above. | | | | | | ADDRESS (Street, city or town, state) <i>4896 BATTERY LANE, BETHESDA, MD.</i> | | DATE SIGNED <i>11/3/66</i> | |
| ACTUAL SIGNATURE <i>Charles J. Salvatore, Jr.</i> | | | | | | | | | |
| PHYSICIAN'S NAME (Type) <i>CHARLES J. SALVATORE, JR.</i> | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>11-6-59</i> | | 22c. NAME OF CEMETERY OR CREMATORIUM <i>Mount Olivet Cemetery</i> | | 22d. LOCATION (City, town, or county) <i>Washington D.C.</i> | | (State) <i>D.C.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Francis J. Collins</i> | | ADDRESS <i>3821-14th St. NW Wash. D.C.</i> | | 24a. REC'D BY REGISTRAR DATE <i>NOV 4 '59</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

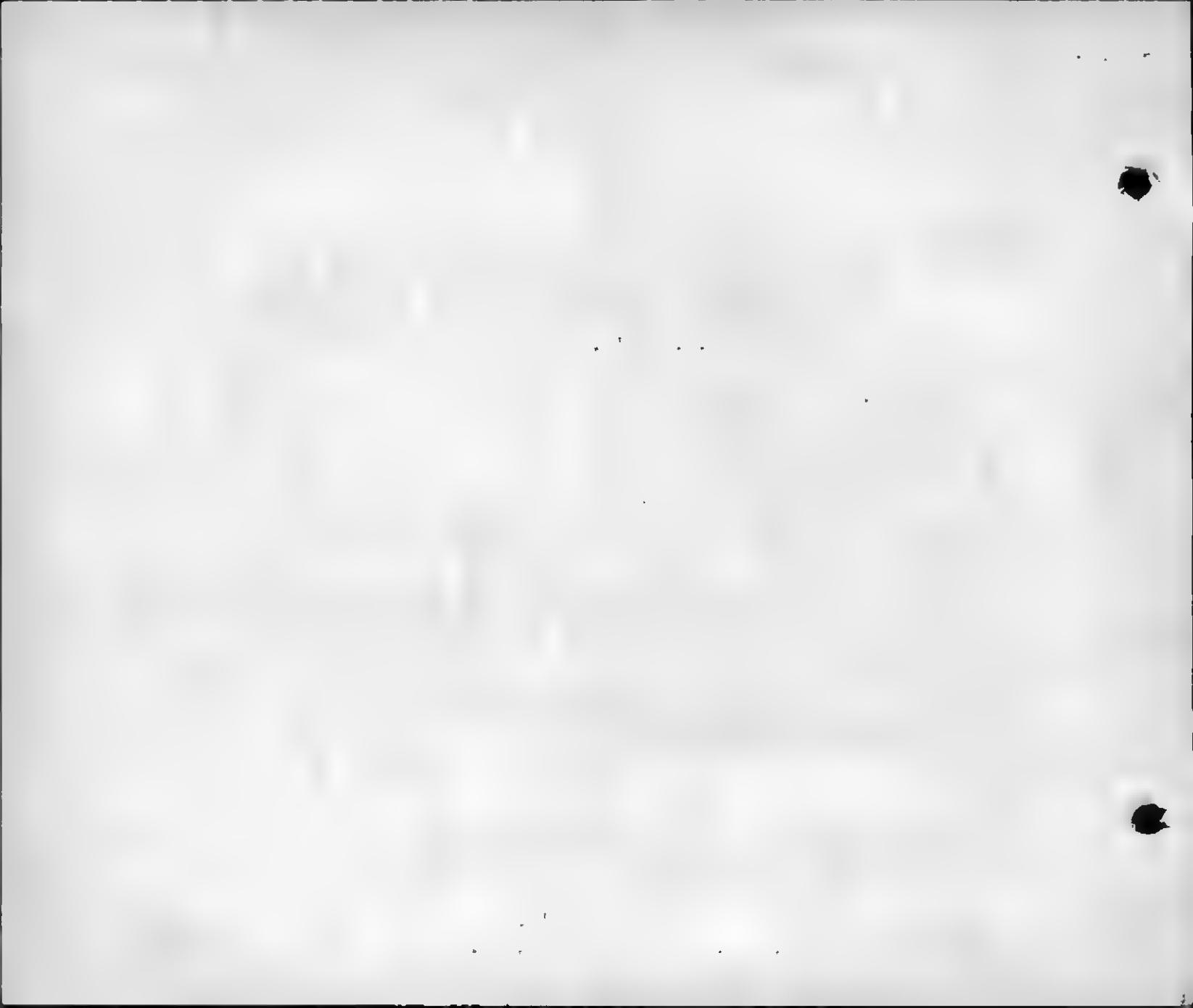
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12738

Reg. Dist. No.

| | | | | | | | | |
|---|--|--|--|--|--|---|------------------------------|-----------|
| 1. PLACE OF DEATH a. COUNTY | | 19770 | | Items v a 1, 1-50 3-12 1/1/1959 | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) | | |
| Montgomery | | MARYLAND | | a. STATE | | b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | d. STREET ADDRESS | | |
| Silver Spring | | | | Washington | | 47 x 2 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| Argyle Country Club | | | | 1329 Fort Stevens Dr. | | | | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle | Lost | 4. DATE OF DEATH | Month | Day | Year |
| Franklin Thomas Houston | | | | | Nov 1 | | | 1959 |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (in years at birth) 1/1/1905 1/1/54 yrs | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | Hours Min |
| Male | | White | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B+19 H19 W14 H1 | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| elevator Inspector | | | D.C. Gov't. | | Ohio | | U.S.A. | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | Address | | | |
| Charles E. Huston | | | Martha Lyons | | Dorothy Houston | | | Street 2 |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) | | | | | | | | |
| yes | | WW # 2 | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion | | | | | | | | |
| 420.1 DUE TO | | | | | | | | |
| Candidias, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) | | | | | | | | |
| DUE TO | | | | | | | | |
| (c) | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH sudden | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | |
| Collapse on golf course while playing golf | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | |
| EXAMINER'S NAME (Type) | | DATE 11-1-59 | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 11/4/59 | 22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NAT'L. CEMETERY | | 22d. LOCATION (City, town, or county) ARLINGTON, VIRGINIA | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. ADDRESS Raymond A. Ziska SILVER SPRING, MD. | | | | | | | | |
| 24a. REC'D BY REGISTRAR DATE NOV 4 '59 | | | | | 24b. REGISTRAR'S SIGNATURE Carter S. Knott | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

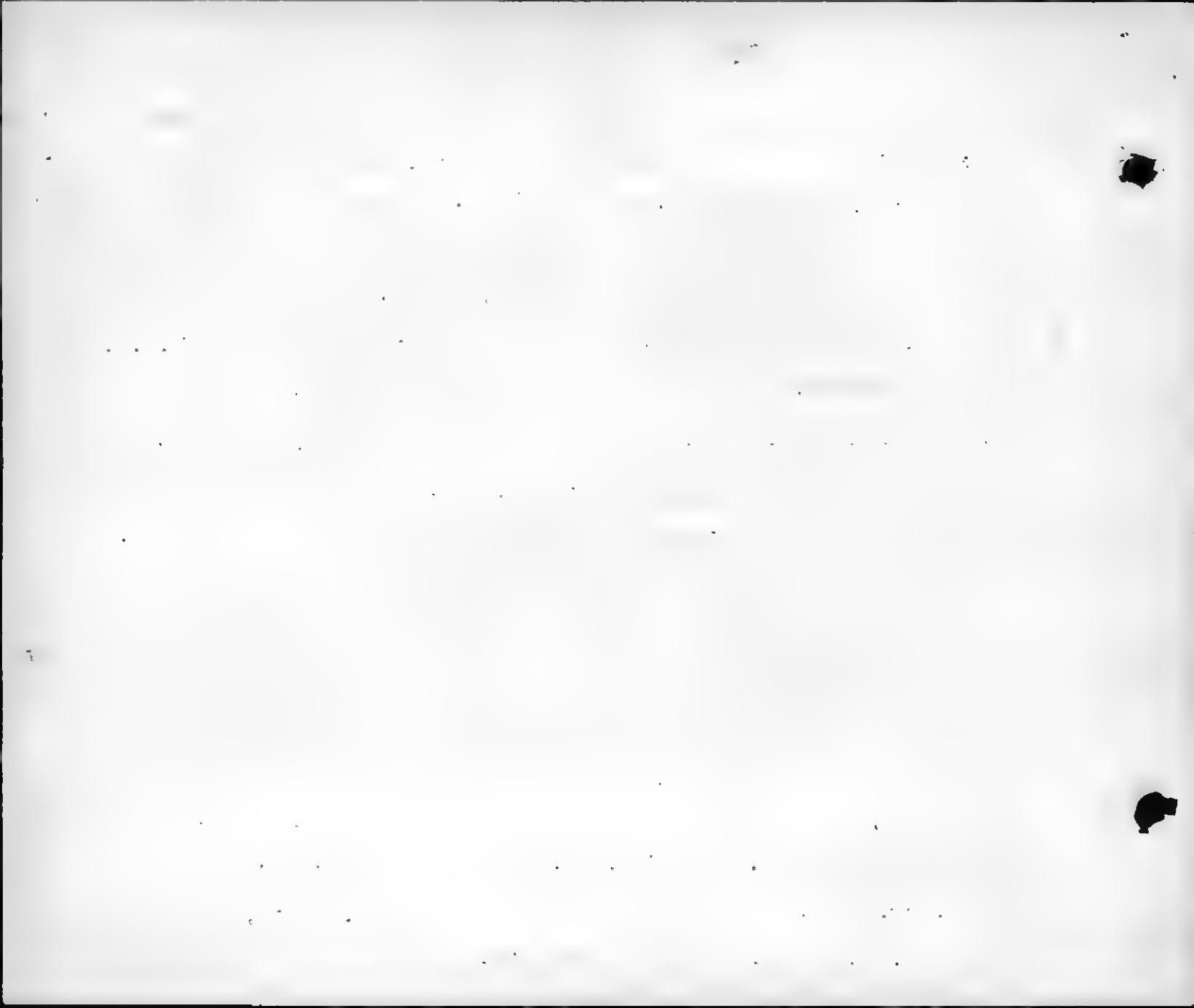
12771

CERTIFICATE OF DEATH

Reg. Dist. No.

12739

| | | | | | | | | | |
|--|--|---|---|---|---|---|------------------|--|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Rural | | Maryland | | b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington | | c. LENGTH OF STAY IN 1b 6 months | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | | d. STREET ADDRESS 26 W. Montgomery Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Le Deau Gardens Rest Home | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Lois | | First | Middle | Last | 4. DATE OF DEATH Howley | Month November | Day 17 | Year 1959 | |
| 5. SEX Female | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 31, 1887 | | 9. AGE (In years from birthday) 72 yrs. | | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Missouri | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Henry Greschner | | 14. MOTHER'S MAIDEN NAME Laura Bell Stone | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 064-20-0252 | | INFORMANT Theresa Maury-daughter-Item #2 | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Acute Exhaustion, Exsanguination | | | | | | | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) | | Bleeding diverticulitis | | | | | | | |
| DUE TO (c) | | 1 week | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic infection, left hip: Old fracture, left hip | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from _____ alive on _____ | | Jun. 1958, to Nov. 17, 1959 | | | | | | DATE SIGNED | |
| alive on Nov. 15, 1959 | | and that death occurred at 8:40 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL TIME | | <i>Robert T. Thibadeau</i> M.D. | | | | | | ADDRESS (Street, city or town, state) 10609 Concord Street | |
| PHYSICIAN'S NAME (Type) | | Robert T. Thibadeau, M.D. | | | | | | Kensington, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Trans.Bur. | | 22b. DATE THEREOF 11-20-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Calvary Cemetery | | 22d. LOCATION (City, town, or county) St. Louis, Missouri | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland | | ADDRESS Arthur S. Francis | | | | | | 24a. REC'D BY REGISTRAR DATE NOV 23 1959 | |
| | | | | | | | | 24b. REGISTRAR'S SIGNATURE | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12772

CERTIFICATE OF DEATH

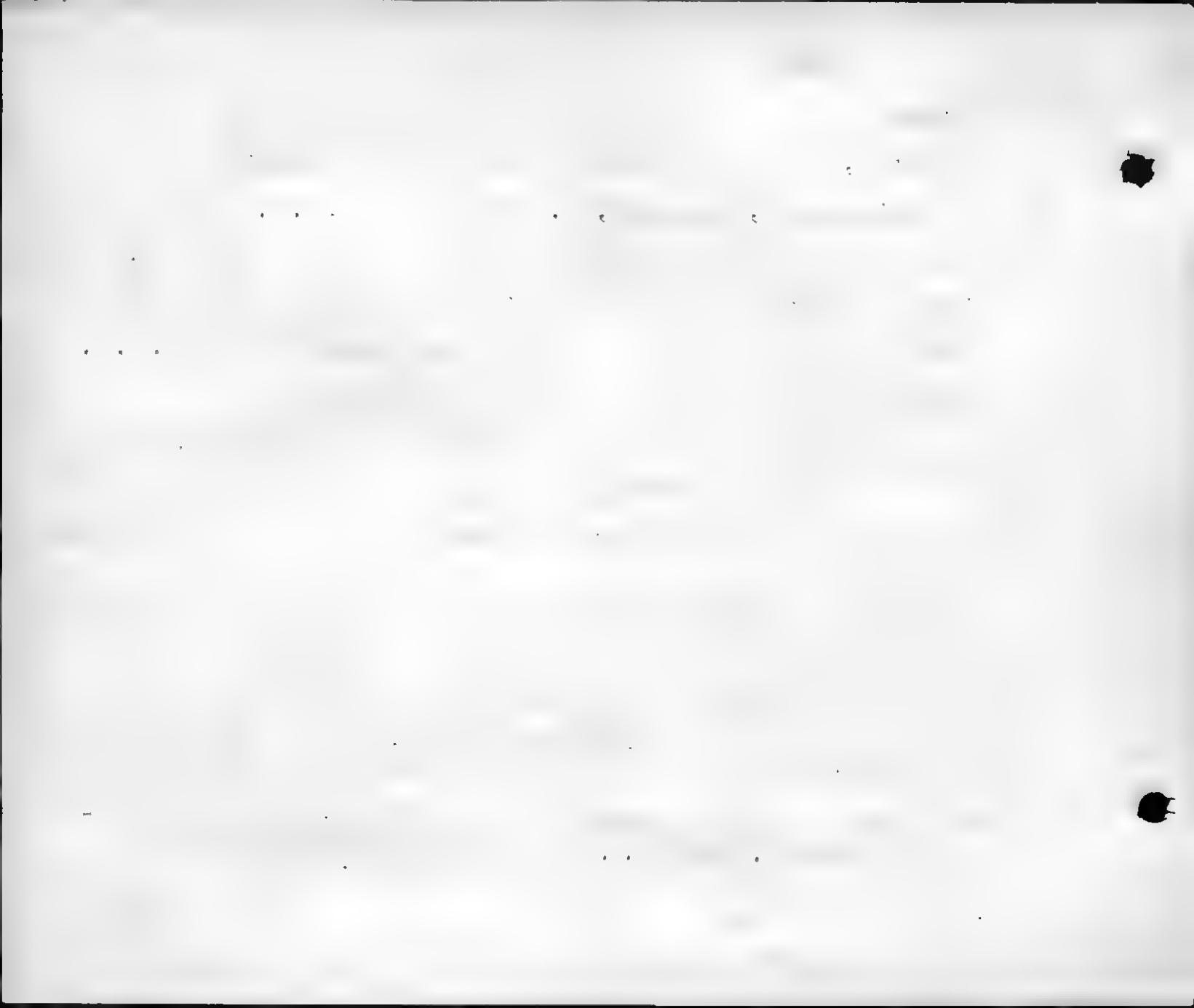
Reg. Dist. No.

12740

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | |
|--|--|---|---|--|---|--|---------------------|---------------------------|-------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, | | c. LENGTH OF STAY IN 1b 36 days | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND | | b. COUNTY | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) The District of Columbia | | f. STREET ADDRESS 4602 4th Street, N. W. | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First EDGAR | Middle LEE | Last HUNT | 4. DATE OF DEATH November 3, 1959 | Month November | Day 3 | Year 1959 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH March 25, 1953 | 9. AGE (In years last birthday) 6 yrs. | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Days 0 | Hours 0 | Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) West Virginia | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | | |
| 13. FATHER'S NAME Camden Hunt | 14. MOTHER'S MAIDEN NAME Elenore Gande | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. none | INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH 10 days | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 204.5 | | DUE TO Pneumonia and septicemia | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) | | DUE TO Acute lymphatic leukemia | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | DUE TO - | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Ripley | | (County) W. Va. | (State) W. Va. |
| 21. I certify that I attended the deceased from alive on November 3, 1959 , and that death occurred at 12:05 P.M. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) The Clinical Center | | | | | | | DATE SIGNED 11-3-59 |
| ACTUAL SIGNATURE Lawrence A. Gaydos | | M.D. National Institutes of Health | | | | | | | |
| PHYSICIAN'S NAME (Type) Lawrence A. Gaydos, M.D. | | Bethesda 14, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) cremation | | 22b. DATE THEREOF 11/4/59 | | 22c. NAME OF CEMETERY OR CREMATORIAL - | | 22d. LOCATION (City, town, or county) Ripley | | | (State) W. Va. |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO. | | ADDRESS 1406 Chapin St NW | | 24a. REC'D BY REGISTRAR Wash. D.C. | | 24b. REGISTRAR'S SIGNATURE Charles E. Thomas | | | |
| | | | | DATE NOV 5 '59 | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12741

12773

1. PLACE OF DEATH

o. COUNTY
Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN 1b
RURAL and give nearest town)

2 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

o. STATE
Arizona

b. COUNTY

e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Saw Mill

41 X

d. STREET ADDRESS

(none)

e. IS RESIDENCE
ON A FARM?YES NO

050

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATHMonth
NovemberDay
15, 1959

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

Male

White

WIDOWED DIVORCED

8. DATE OF BIRTH

June 3, 1953

9. AGE (In years
lost birthday)
yrs.

Months

IF UNDER 1 YEAR

Days

IF UNDER 24 HRS

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Child

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Missouri

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Frank Hutchison

14. MOTHER'S MAIDEN NAME

Leada Corbin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

INFORMANT The Medical Record Address

The Clinical Center, Bethesda 14, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

Septicemia

INTERVAL BETWEEN
ONSET AND DEATH

11-16-59 DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last

(b)

DUE TO

Gastrointestinal Hemorrhage

Hours

(c)

Acute leukemia

1 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)

20c. TIME OF INJURY Month, Day, Year
Hour o. m.
p. m.20d. INJURY OCCURRED
While at work Not while at work 20e. PLACE OF INJURY (Name, form,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from November 13, 1959, to November 15, 1959, that I last saw the deceased alive on November 15, 1959, and that death occurred at 11:15 M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Laurence A. Gaydos

M.D.

The Clinical Center

11-16-59

PHYSICIAN'S
NAME (Type)

Laurence A. Gaydos M.D.

National Institutes of Health
Bethesda 14, Maryland22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIAL

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

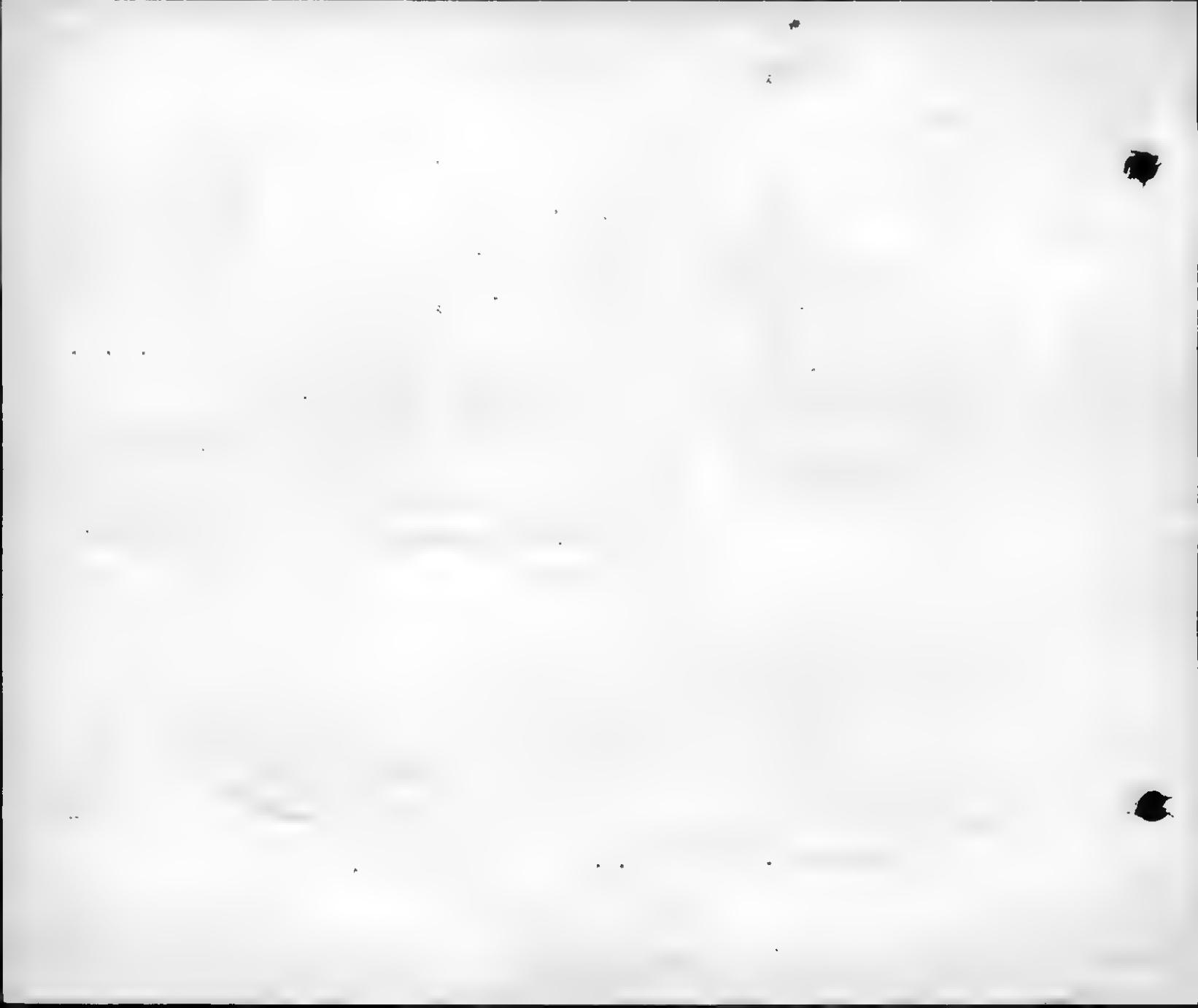
24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

M. W. Chambers Co 1401 Wisconsin St. N.W.
Washington, D.C.

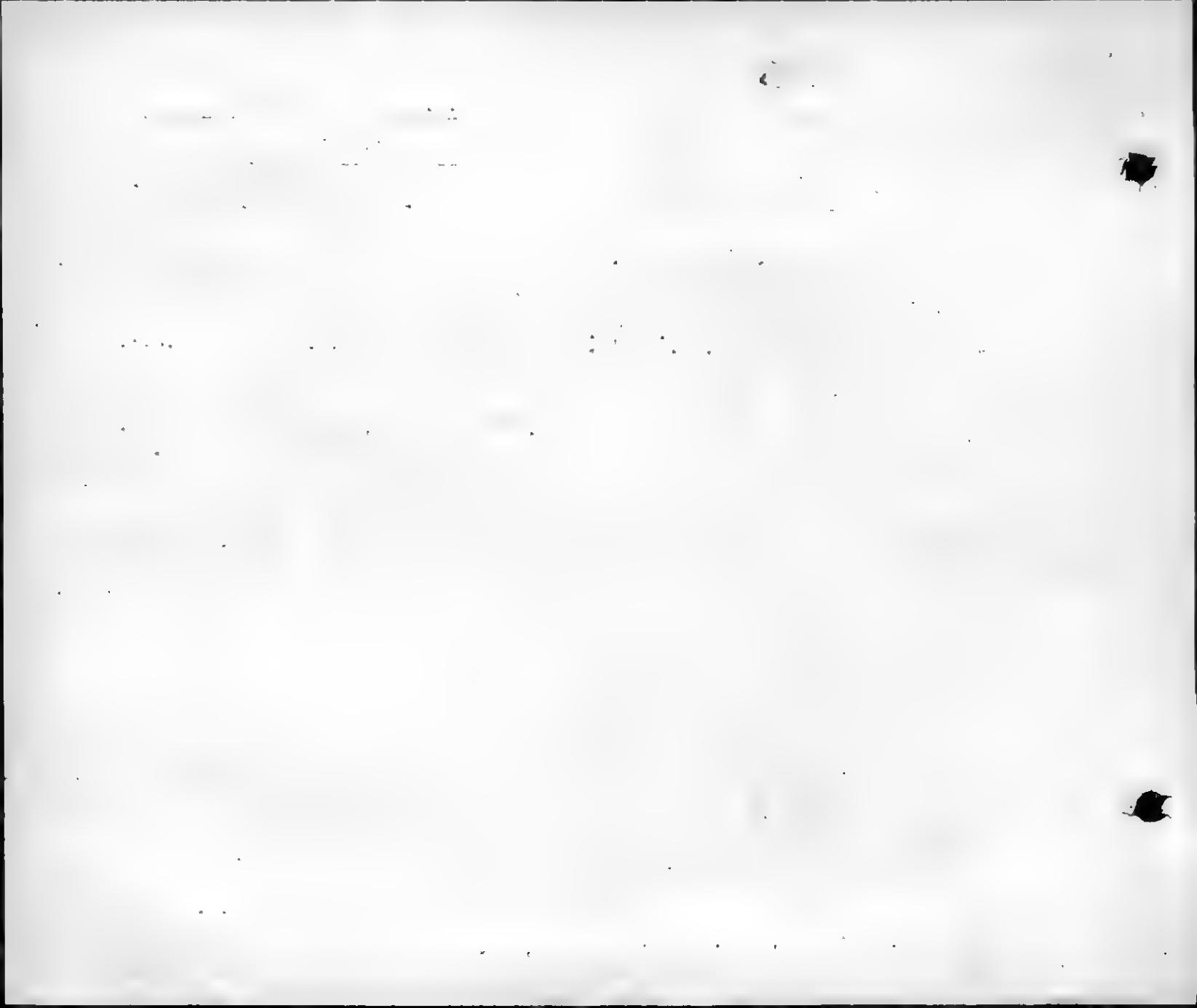
DATE NOV 17 '59

Cecilia & Thomas



TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | | | Reg. Dist. No. 12742 | | | |
|--|--|--|--|---|---------------------------------|--|---------------------------|---|--|-----|--|---|-------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY HU. TOWNSHIP MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. Washington b. COUNTY Washington | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | | | c. LENGTH OF STAY IN lb 2 months | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2111 Forest Glen Road | | | | d. STREET ADDRESS 3800 New Hampshire Ave. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Caroline A. HYAM | | | First | Middle | Last | 4. DATE OF DEATH | Month | Day | Year | | | | | | |
| 5. SEX Female | | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/3/74 | 9. AGE (In years lost birthday) 84 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | Hours | Min | | | | | |
| 10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) retired | | | 10b. KIND OF BUSINESS OR INDUSTRY Press Dept. U. S. Gov't. | | | 11 BIRTHPLACE (State or foreign country) Washington, D.C. | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | |
| 13. FATHER'S NAME Carl Schnebel | | | 14. MOTHER'S MAIDEN NAME Emma Piepenbring | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | | 16. SOCIAL SECURITY NO none | | | INFORMANT Mrs. Evelyn Gwynn, 2111 Forest Glen Rd. Silver Spring, Md. | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 433.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| Myocardial Insufficiency Auricular Fibrillation Arteriosclerosis | | | | | | | | | | | | immediate | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | months | | | |
| | | | | | | | | | | | | in term. | | | |
| | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m p. m. | | | 20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | | | | | |
| | | | | | | | | | | | | | | | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on November 17, 1952 , and that death occurred at 1:43 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>E. L. Marston, M.D.</i> PHYSICIAN'S NAME (Type) 300 Pershing Drive, Silver Spring November 17, 1959 | | | | | | | | | | | | ADDRESS (Street, city or town, state) | DATE SIGNED | | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) BURIAL | | | 22b. DATE THEREOF 11/19/59 | | | 22c. NAME OF CEMETERY OR CREMATORIUM GLENWOOD CEMETERY | | | 22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C. | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska | | | ADDRESS SILVER SPRING, MD. | | | 24a. REC NOV 19 '59 DATE NOV 19 '59 | | | 24b. REGISTRAR'S SIGNATURE Charles J. Treanor | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12775

CERTIFICATE OF DEATH

Reg. Dist. No.

12743

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CORONER NOTIFIED & WILL APPROVE.

MEDICAL CERTIFICATION

| | | | | | | | | | | | |
|--|--|--|--|--|---------------------------------|--|-----------------|---|------------|---------|------|
| 1 PLACE OF DEATH a. COUNTY | | MONTGOMERY MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | Maryland | | b. COUNTY | Montgomery | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | Rock Creek Hills, Kensington | | | | | |
| Kensington Rock Creek Hills | | | | d. STREET ADDRESS | | 9528 Kensington Parkway | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 8 NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9528 Kensington Parkway | | | | 4. DATE OF DEATH | | Month | November 9, | Day | Year | | |
| 3 NAME OF DECEASED (Type or print) | | First DAVID | Middle M. IACONE | Last | | Month | November | Day | Year | | |
| 5. SEX | | 6. COLOR OR RACE | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS | Months | Days | Hours | Min. |
| Male | | White | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | Nov. 14, 1909 | 49 yrs | 11 25 | | | | | |
| 10a USUA. OCCUPATION (Give kind of work done during most of working life even if retired) | | 10b KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | | | |
| Owner-Manager | | Dry-Cleaning Est. | | Philadelphia, Penna. | | U. S. | | | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | | | | | | | |
| Amedeo Constantine Iacone | | Mary Grosso | | | | | | | | | |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II | | 16. SOCIAL SECURITY NO. | | INFORMANT Wife | | Address | | | | | |
| | | 579-03-2811 | | Ellis H. Iacone | | Same as Item #2 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | DUE TO | | COPD Mary Thrombosis | | INTERVAL BETWEEN ONSET AND DEATH 10 days | | | | | |
| 420.1 | | (b) | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) | | DUE TO | | | | | | | | | |
| | | | | | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | |
| 19 | | 9 NOV | | 9 NOV | | 9 NOV | | 9 NOV | | 1959 | |
| 21. I certify that I attended the deceased from olive on | | 9 NOV 1959 | | 9 NOV 1959 | | 9 NOV 1959 | | 9 NOV 1959 | | 1959 | |
| ACTUAL SIGNATURE WILLIAM H. BEARD. | | | | | | | | | | | |
| PHYSICIAN'S NAME (Type) | | WILLIAM H. BEARD | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11-13-59 | | 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington Nat'l Cem. Bethesda, Md. | | 22d. LOCATION (City, town, or county) Arlington, Virginia | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY | | | | | | 24a. REC'D BY REGISTRAR NOV 13 '59 | | 24b. REGISTRAR'S SIGNATURE Clement S. Thomas | | | |
| | | | | | | DATE | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12776 CERTIFICATE OF DEATH

Reg. Dist. No.

12744

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE D.C. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | c. LENGTH OF STAY IN 1b 9 or 10 mos. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LeDeau Nursing Home | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47X-? | |

| | | | | | | |
|--|--------------------------------|---|-----------------------------------|---|-----------------------------------|----------------------------------|
| 3. NAME OF DECEASED (Type or print) | First <i>SARAH CAROLINE</i> | Middle | Last <i>IVERSON</i> | 4. DATE OF DEATH Month 11 | Day 21 | Year 1959 |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 8, 1873 | 9. AGE (in years last birthday) 86 yrs | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS Hours Min. |

| | | | |
|--|---|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | 11. BIRTHPLACE (State or foreign country) Connecticut | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
|--|---|--|--|

| | |
|---|---|
| 13. FATHER'S NAME Peter Holland | 14. MOTHER'S MAIDEN NAME Louise Hansmann |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | 16. SOCIAL SECURITY NO. none |
| INFORMANT Mr. G. P. Iversen, 1208 Geranium St., N.W. Washington, D.C. | Address |

| | |
|---|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Inflammation</i> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Generalized arteriosclerosis and senility</i> DUE TO (c) <i>Carcinoma right breast (Paget's disease)</i> | INTERVAL BETWEEN ONSET AND DEATH 1 year |
|---|---|

| |
|--|
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Carcinoma right breast (Paget's disease)</i> |

| | | | | | |
|--|---|--|---------------------|----------|---------|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |

| |
|--|
| 21. I certify that I attended the deceased from <i>August 2, 1955</i> , to <i>11-21-59</i> that I last saw the deceased alive on <i>11-20-59</i> , and that death occurred at <i>5:00 P.M.</i> from the causes and on the date stated above. |
|--|

| | |
|--|---|
| ADDRESS (Street, city or town, state) <i>Jason Geiger</i> | DATE SIGNED <i>11-21-59</i> |
| ACTUAL SIGNATURE <i>Jason Geiger</i> | PHYSICIAN'S NAME (Type) JASON GEIGER |

| | | | |
|---|-------------------------------|---|--|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 11/24/59 | 22b. DATE THEREOF 11/24/59 | 22c. NAME OF CEMETERY OR CREMATORIUM WHITNEYVILLE CEMETERY | 22d. LOCATION (City, town, or county) HAMDEN, CONN. |
| 23. FUNERAL DIRECTOR'S SIGNATURE RAYMOND A. ZUSKA INC. | ADDRESS SILVER SPRING, MD. | 24a. REC'D BY REGISTRAR NOV 24 '59 | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12777

CERTIFICATE OF DEATH

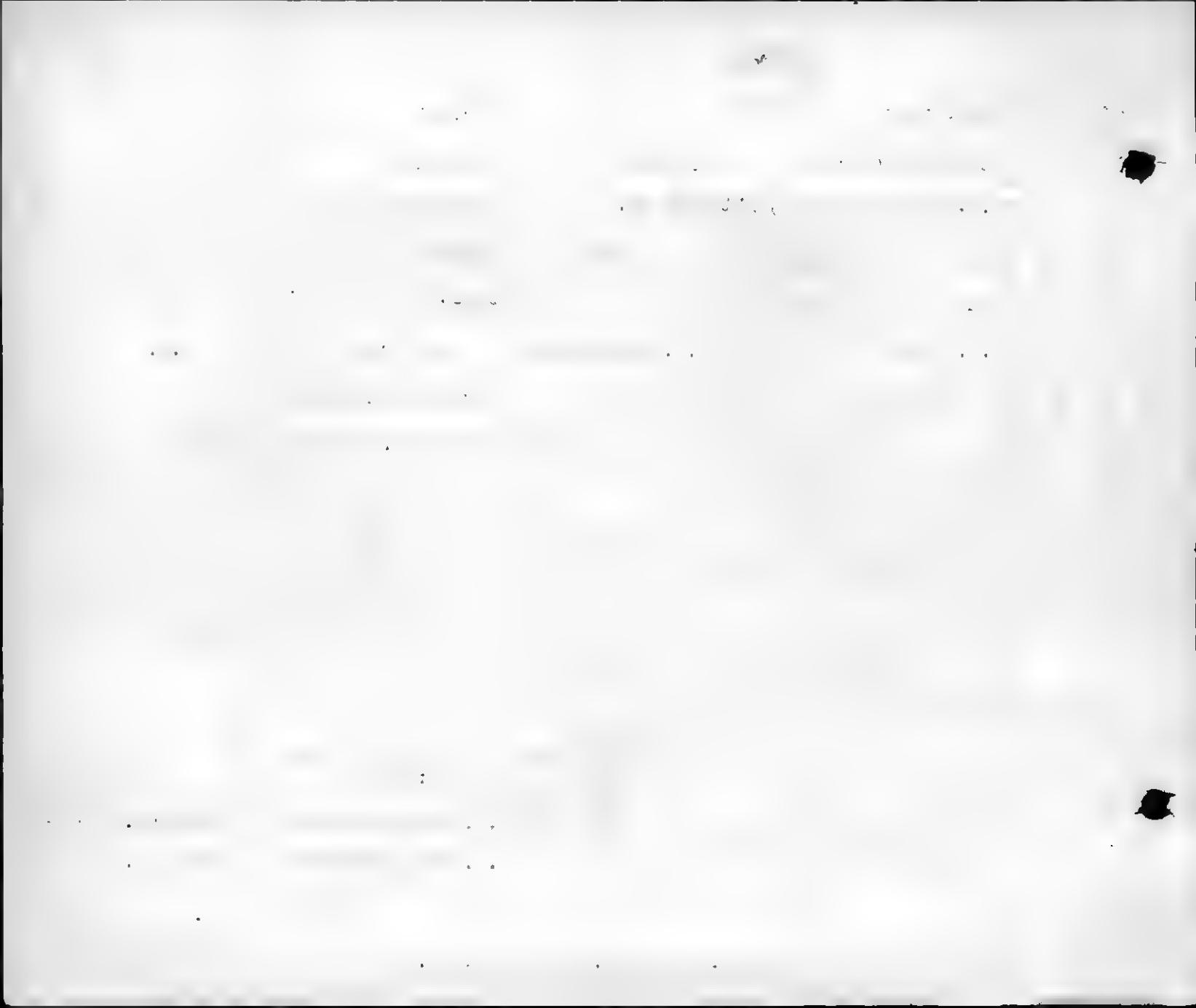
Reg. Dist. No. 215

12745

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

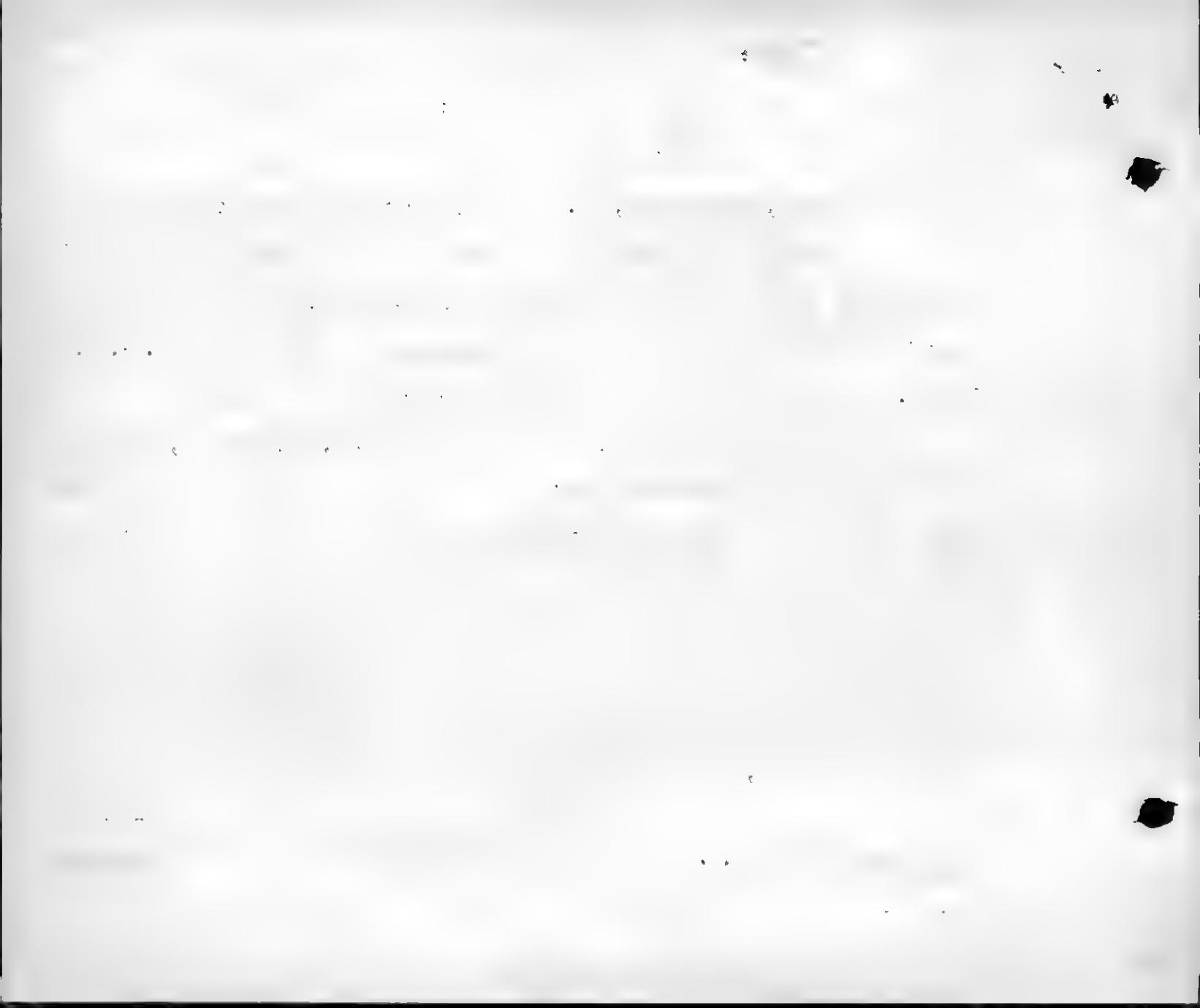
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|----------------------------------|---|--|---|---|---|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Virginia | | b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN lb 17 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annadale | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md. | | d. STREET ADDRESS 1202 Bristow Drive | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First James | Middle Vincent | Last JENSEN | 4. DATE OF DEATH November | Month 30 | Day 19 59 | Year |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-15-21 | 9. AGE (In years last birthday) 38 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS Days 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Government | | 11. BIRTHPLACE (State or foreign country) California | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Jens JENSEN | | | | 14. MOTHER'S MAIDEN NAME Caroline GORGESSEN | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If no or unknown) <input type="checkbox"/> Yes | | (If yes, give war or dates of service) WW II | | 16. SOCIAL SECURITY NO. | | INFORMANT (Wife) Audery H. Jensen | |
| 17. ADDRESS | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | | |
| 444X DUE TO Renal Failure INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b). Malignant hypertension ONSET AND DEATH } 2 mo | | | | | | | |
| DUE TO Renal Failure } 2 mo | | | | | | | |
| DUE TO Malignant hypertension } 10 yrs | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 13 November, 19 59 , to 30 November, 19 59 , that I last saw the deceased alive on 30 November, 19 59 , and that death occurred at 10:30 AM from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 11-30-59 | | | | | | | |
| ACTUAL SIGNATURE Fred H O'Connell | | | | | | | |
| PHYSICIAN'S NAME (Type) Fred H. O'CONNELL | | | | | | | |
| U.S. Naval Hospital, Bethesda Md. | | | | | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-3-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Arlington National | | 22d. LOCATION (City, town, or county) Arlington Va. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home | | | | ADDRESS 2847 Wilson Blvd. Arlington, | | 24a. REC'D BY REGISTRAR Dec 2 '59 | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE Arnold S. Krause | |



TO HOSPITAL OR VENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | Reg. Dist. No. 12746 | | |
|--|--|---|--|---|--|---|--|--|---|---|-----|------|
| 12778 CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE Arizona b. COUNTY Tucson c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 41 X d. STREET ADDRESS 1515 North Columbus Boulevard | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 223 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Judith | | First Charlotte | | Middle Jones | | Last | | 4. DATE OF DEATH November 11 1959 | | Month | Day | Year |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH September 20, 1941 | | 9. AGE (In years last birthday) 18 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Michigan | | | | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | |
| 13. FATHER'S NAME Milton C. Miller | | | | | 14. MOTHER'S MAIDEN NAME Lorna Hafner | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO Unascertainable | | INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | | | | | | |
| 18. CAUSE OF DEATH [Enter any one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO 173X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Metastatic Choriocarcinoma DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 hours | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour p. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | |
| 21. I certify that I attended the deceased from April 2, 1959 , to November 11, 1959 , that I last saw the deceased alive on November 11, 1959 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Saul Genuth</i> M.D. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11-11-59 PHYSICIAN'S NAME (Type) SAUL GENUTH, M.D. | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL Trans. Bur. | | 22b. DATE THEREOF 11-12-59 | | 22c. NAME OF CEMETERY OR CREMATORY Southlawn Cemetery | | 22d. LOCATION (City, town, or county) Tucson, Arizona | | (State) | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland | | | | | ADDRESS | | 24a. REC'D BY REGISTRAR NOV 13 '59 | | 24b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i> | | | |
| VS A1S (4) 1SM 9/5B | | | | | | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12747

12779

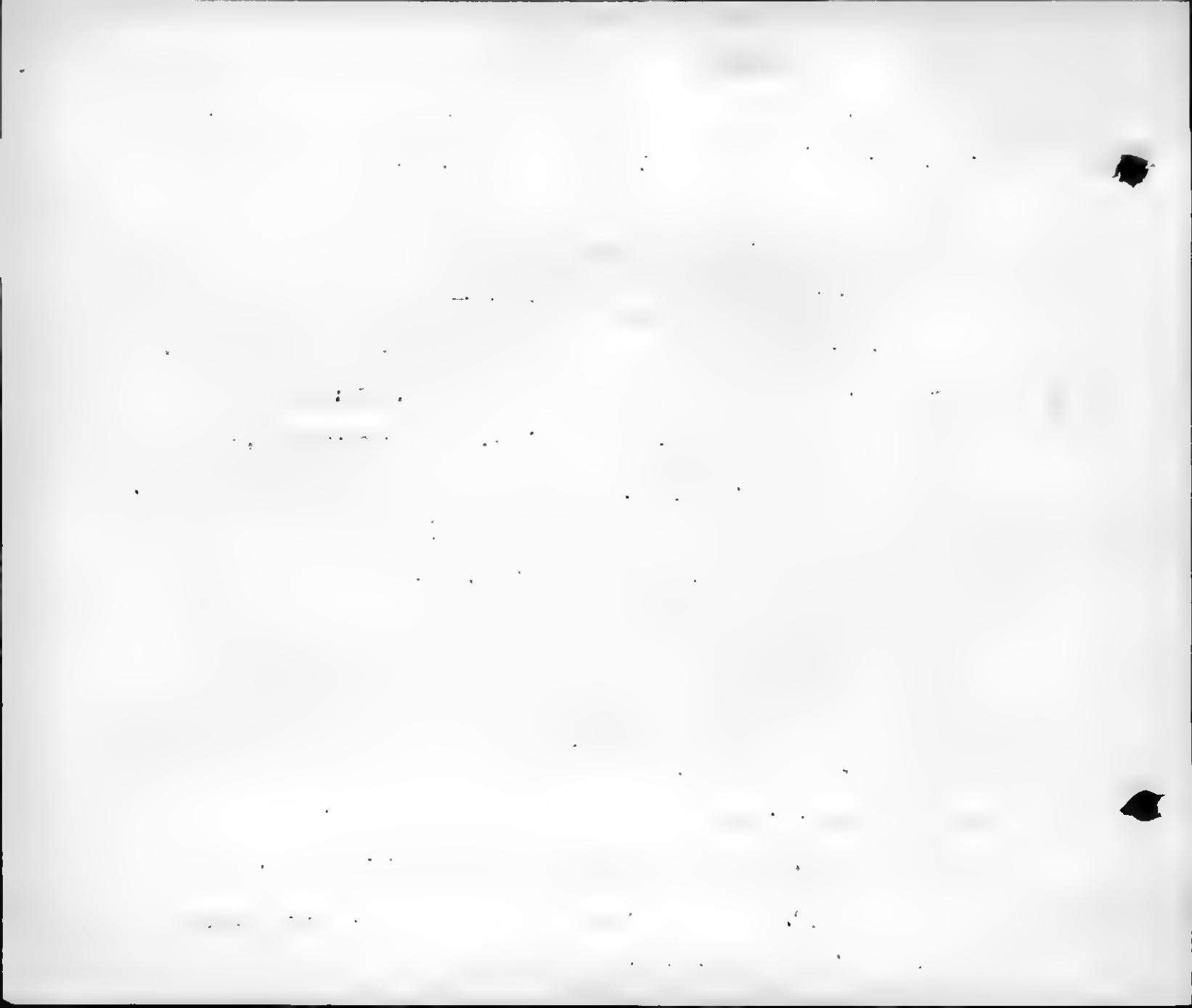
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--|--|---------------------------------------|---|---------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland | | b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville | | c. LENGTH OF STAY IN 1b 50 yrs | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville | | d. STREET ADDRESS _____ | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Nellie | Middle Jane | Last Jones | 4. DATE OF DEATH | Month Nov | Day 1 | Year 1959 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH July 8-1879 | 9. AGE (In years last birthday) 80 yrs | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS Days 0 | Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Edward Titus | | | | 14. MOTHER'S MAIDEN NAME Mary K. McKimney | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. NEKA | | INFORMANT William Jones, Poolesville, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | |
| PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) Cerebral Thrombosis, Acute | | | | | | | |
| DUE TO 32X | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis | | | | | | | |
| DUE TO (c) Generalized Arteriosclerosis | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 15 min | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from October, 1949 , to 1 November, 1959 , that I last saw the deceased alive on 30 October, 1959 , and that death occurred at 7:15 AM , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) Barnesville, Md. | | | | | | | |
| DATE SIGNED 1 Nov 59 | | | | | | | |
| ACTUAL SIGNATURE Gordon M. Smith | | | | | | | |
| PHYSICIAN'S NAME (Type) Gordon M. Smith | | | | | | | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/3/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Monocacy | | 22d. LOCATION (City, town, or county) (State) Beallsville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton Barnesville Md. | | | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE NOV 4 '59 | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Trahan | |

TO HOSPITAL OR
 may be retained
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

death. Page 4



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

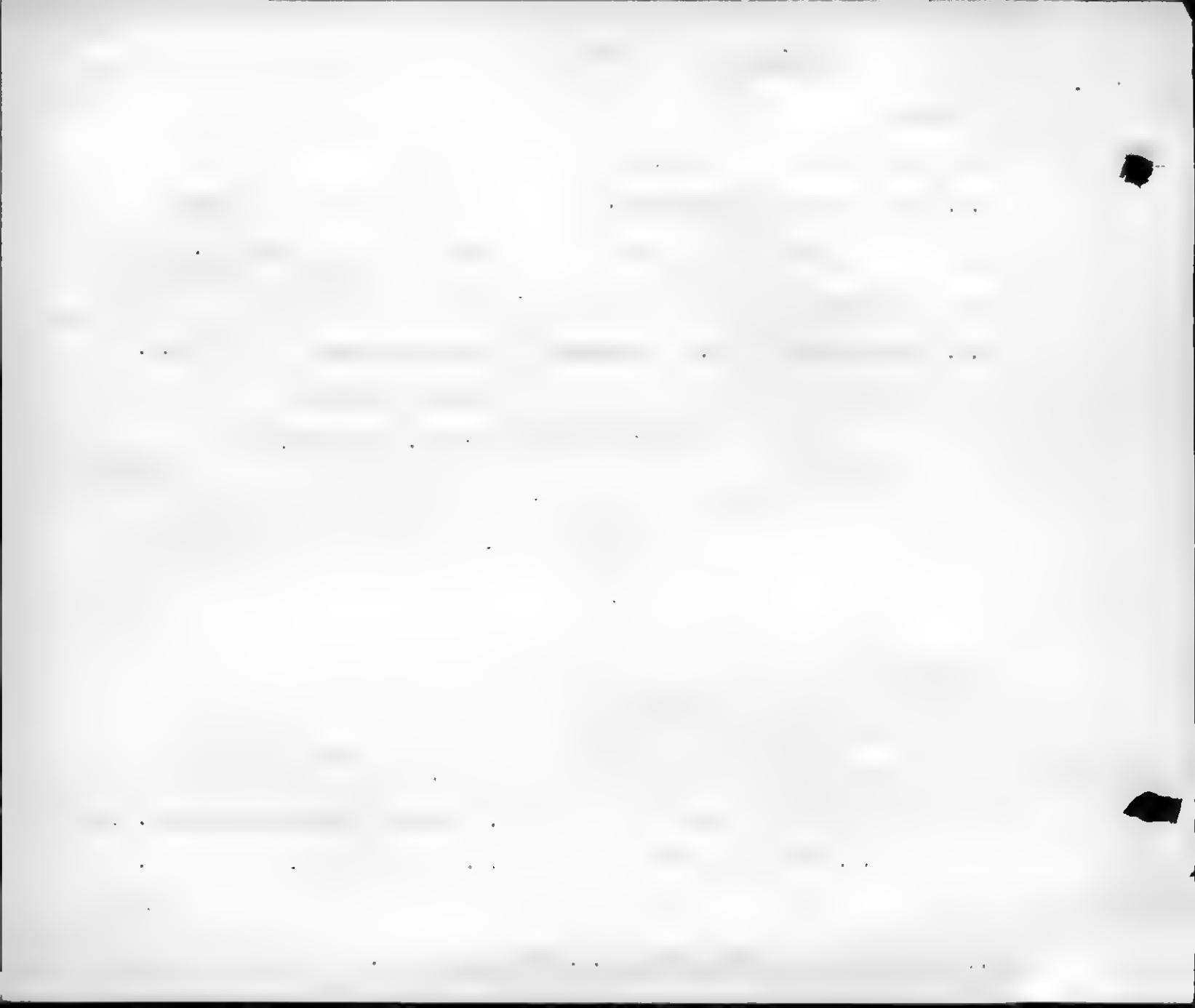
12748

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | | | | |
|---|----------------------------------|---|---|---|---------------------------------------|---|---------------------|------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE North Carolina | | b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 30 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cherry Point | | d. STREET ADDRESS 72 X 511 "B" Enlisted Mens Quarters | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md. | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | First Robert | Middle Leroy | Last JONES | 4. DATE OF DEATH November 23 1959 | Month November | Day 23 | Year 1959 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-30-15 | 9. AGE (in years last birthday) 44 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. Days 0 | Hours 0 | Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Government | | 11. BIRTHPLACE (State or foreign country) South Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | |
| 13. FATHER'S NAME Horace JONES | | | 14. MOTHER'S MAIDEN NAME Elizabeth KINSEY | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO 249 05 2015 | | INFORMANT (Wife) Vera B. JONES | | Address Same as #2 | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 200.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Lymphosarcoma Reticulum Cell type | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 5 months | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | |
| 20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | |
| 20d. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from 24 October, 1959 , to 23 November, 1959 , that I last saw the deceased alive on 23 November, 1959 , and that death occurred at 7:23 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED William B. Baker 11-24-59 | | | | | | | | |
| ACTUAL SIGNATURE | | M.D. U.S. Naval Hospital, Bethesda Md. | | | | | | |
| PHYSICIAN'S NAME (Type) | | W.P. BAKER LT MC USN | | | | | | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11-27-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Buckhead Church Cemetery | | 22d. LOCATION (City, town, or county) Bamberg, South Carolina | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers by Lee Siron | | ADDRESS 1400 Chapin Street N.W. Washington, D.C. | | 24a. REC'D BY REGISTRAR NOV 27 '59 | | 24b. REGISTRAR'S SIGNATURE C. L. S. Kinner | | |

TO HOSPITAL OR
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12749

12781

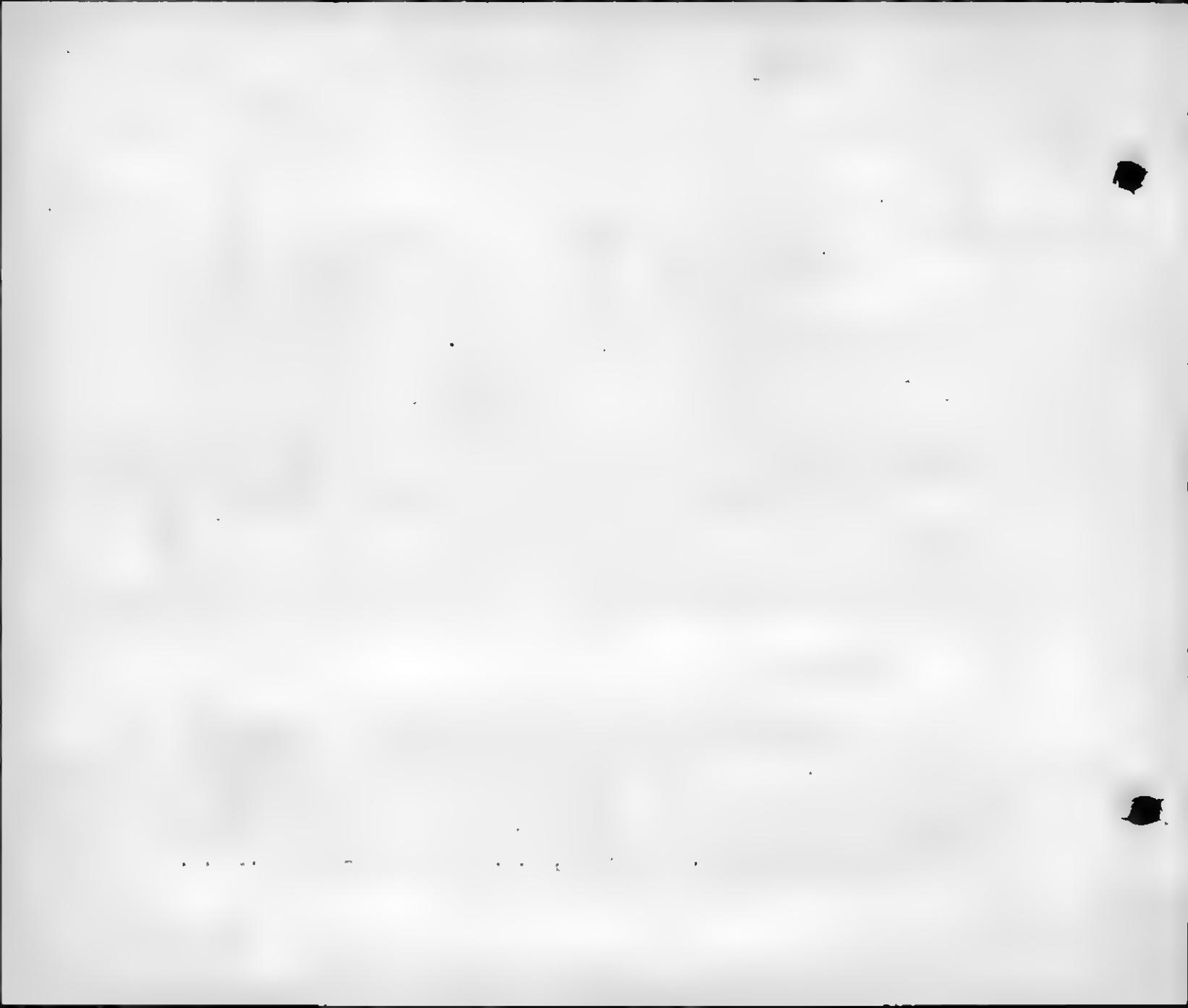
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i> | c. LENGTH OF STAY IN 1b <i>11 yrs</i> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3503 Woodbine St.</i> | d. STREET ADDRESS <i>3503 Woodbine St</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) <i>RYLAND LEE JOYNER</i> | First | Middle | Last |
| 4. DATE OF DEATH <i>November 28 1959</i> | Month | Day | Year |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>7-7-1895</i> |
| 9. AGE (In years last birthday) <i>64 yrs</i> | 10. IF UNDER 1 YEAR Months <i>0</i> | 11. IF UNDER 24 HRS. Days <i>0</i> | 12. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Salesman</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Virginia</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Chastine J Joyner</i> | | 14. MOTHER'S MAIDEN NAME <i>Belle E. ?</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>578-07-2863</i> | |
| 17. INFORMANT <i>Helene C Joyner</i> | | Address <i>3503 Woodbine St Chevy Chase Md.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anymalrophic Tentral Sclerosis approx 1/2 yr</i> | | INTERVAL BETWEEN ONSET AND DEATH, DUE TO | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i></i> | | (c) | |
| Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i></i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>July 1958</i> to <i>November 28 1959</i> , that I last saw the deceased alive on <i>11-28 1959</i> , and that death occurred at <i>6:30 A.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Stanley M. Silverberg M.D.</i> | | ADDRESS (Street, city or town, state) <i>3131 16th St. NW</i> DATE SIGNED <i>11-28-59</i> | |
| PHYSICIAN'S NAME (Type) <i>Stanley M. Silverberg</i> | | 3131-16th St., N.W. 11/28/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>12/2/59</i> | |
| 22c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington National</i> | | 22d. LOCATION (City, town, or county) <i>Arlington Va</i> (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank Sears Sons Co</i> | | ADDRESS <i>3605-14 St NW Wash. D.C.</i> | |
| 24a. REC'D BY REGISTRAR DATE <i>NOV 30 1959</i> | | 24b. REGISTRAR'S SIGNATURE <i>Carlyle & Evans</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12750

12782

CERTIFICATE OF DEATH

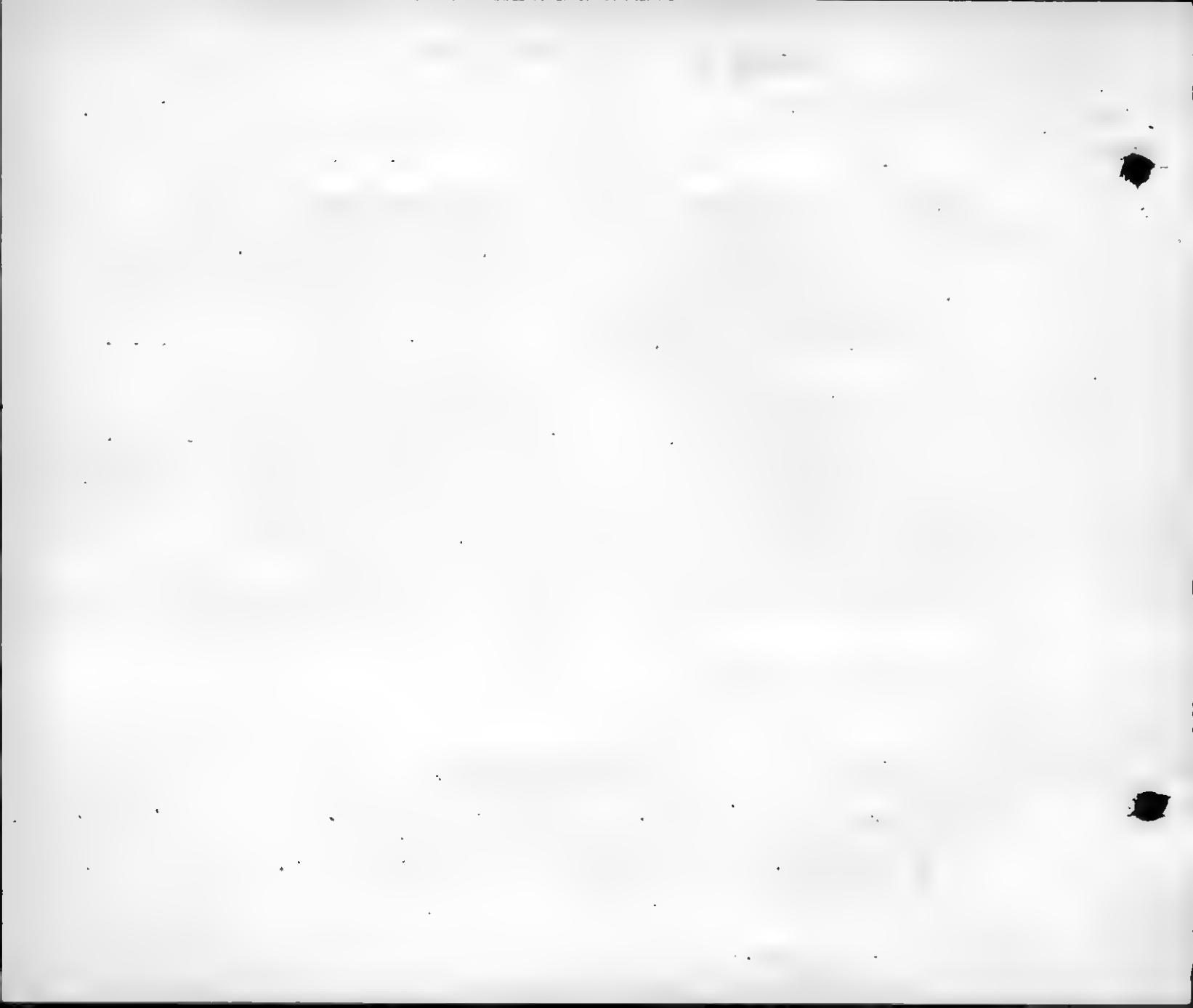
Reg. Dist. No.

| | | | | | | | | |
|---|----------------------------------|---|---|--|---|---|-----------------------|----------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland | | b. COUNTY Montgomery | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairland | | c. LENGTH OF STAY IN 1b 2½ years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Springfield | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fairland Nursing Home | | | | d. STREET ADDRESS 5702 Ogden Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) Fred | | First | Middle | Last | 4. DATE OF DEATH Kaulback | Month November | Day 2 | Year 19 59 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 29, 1872 | 9. AGE (In years last birthday) 87 yrs | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Days 0 | 12. Hours 0 | 13. Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Eng. | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (State or foreign country) California | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Charles Kaulback | | 14. MOTHER'S MAIDEN NAME Mary Loring | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | INFORMANT Mrs. James Osborne - Daughter - Item #2 | | Address | | |
| <p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency 42a1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p> <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) Suitland (State) Maryland | | |
| <p>21. I certify that I attended the deceased from March 19, 1957, to November 2, 1957, that I last saw the deceased alive on October 20, 1959, and that death occurred at 11 P.M., from the causes and on the date stated above.</p> <p>ADDRESS (Street, city or town, state) M.D. 8237 Georgia Ave. Silver Spring, Md.</p> <p>ACTUAL SIGNATURE Caron H. Traum</p> <p>DATE SIGNED Nov 3 '57</p> | | | | | | | | |
| PHYSICIAN'S NAME (Type) Aaron H. | | 8237 Georgia Ave. Silver Spring Md. | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 11-3-59 | | 22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory | | 22d. LOCATION (City, town, or county) Suitland, Maryland | | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland | | ADDRESS Robert A. Pumphrey, Bethesda, Maryland | | 24a. REG'D BY REGISTRAR DATE NOV 5 '59 | | 24b. REGISTRAR'S SIGNATURE Caron H. Traum | | |

HOSPITAL OR CLINIC: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, all in my event within 72 hours after death.

VS A15 (4)
15M 9/58



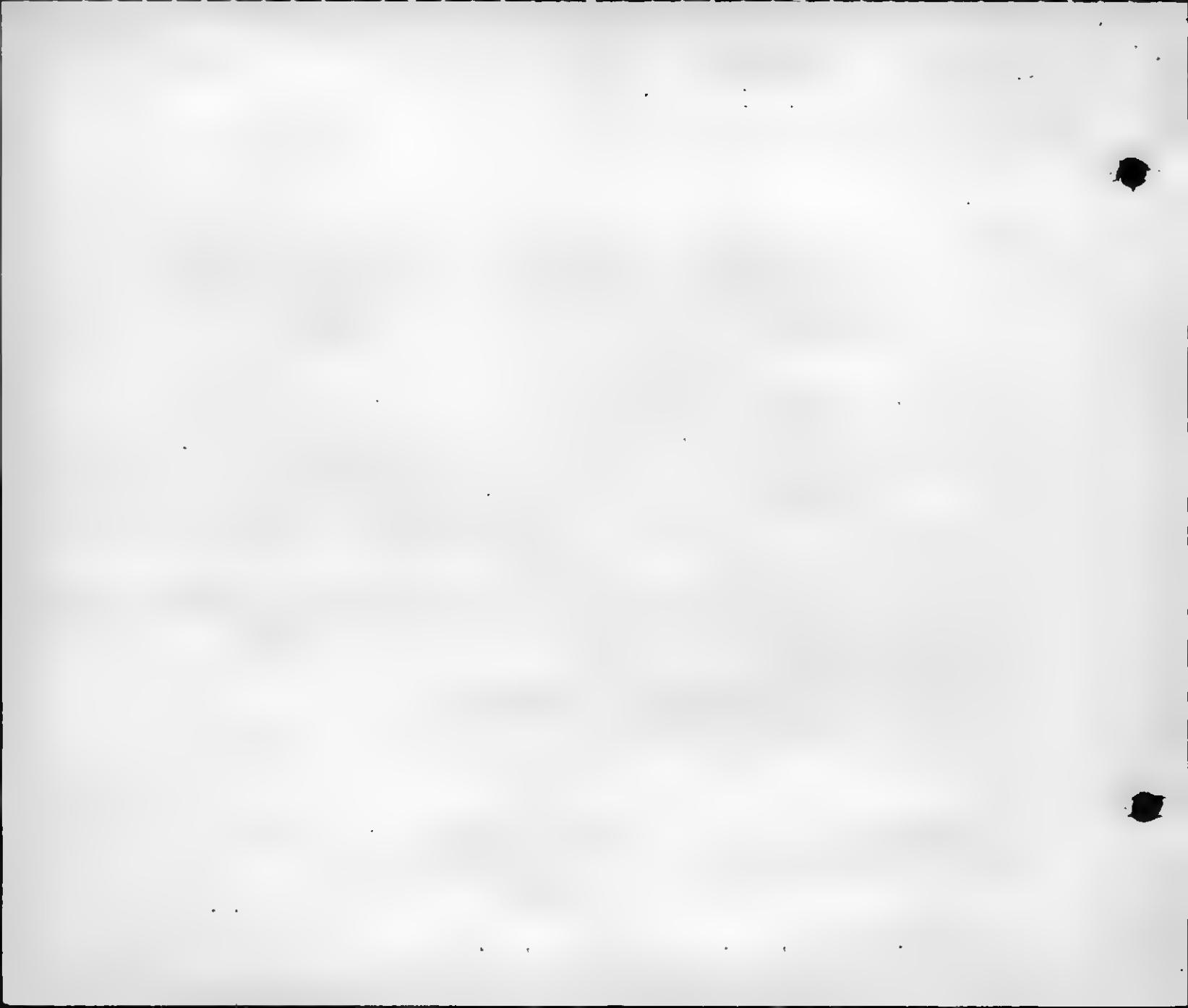
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12751

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | |
|---|---|---|---|--|--------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>13 mo.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10402 Georgia Ave</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10402 Georgia Ave</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>MATILDA F.A. KENDRICK</u> | | 4. DATE OF DEATH <u>Nov 25 1959</u> | IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH <u>July 25 1868</u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | 11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u> | | |
| 13. FATHER'S NAME <u>John George Killian</u> | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Flack</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>878-50-3044</u> | 17. INFORMANT <u>Mrs. Katherine K Sinclair, same</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <u>Atrial fibrillation</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hours</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month <u>Nov</u> , Day <u>25</u> , Year <u>1959</u> Hour <u>a. m.</u> , p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) <u>10110 Georgia Ave</u> | (County) <u>Montgomery</u> | (State) <u>Md.</u> |
| 21. I certify that I attended the deceased from <u>June</u> , 1959, to <u>Nov 25</u> , 1959, that I last saw the deceased alive on <u>Nov 25</u> , 1959, and that death occurred at <u>931A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10110 Georgia Ave</u> DATE SIGNED <u>Nov 25 1959</u> | | | | | |
| ACTUAL SIGNATURE <u>John Lawrence Avery</u> | PHYSICIAN'S NAME (Type) <u>John Lawrence Avery</u> | M.D. <u>10110 Georgia Ave</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>11/28/59</u> | 22c. NAME OF CEMETERY OR CREMATORIAL <u>ROCK CREEK CEMETERY</u> | 22d. LOCATION (City, town, or county) <u>WASHINGTON, D.C.</u> | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY INC.</u> | | ADDRESS <u>SILVER SPRING, MD.</u> | 24a. REC'D BY REGISTRAR <u>DEC 1 '59</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hause</u> | |



TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

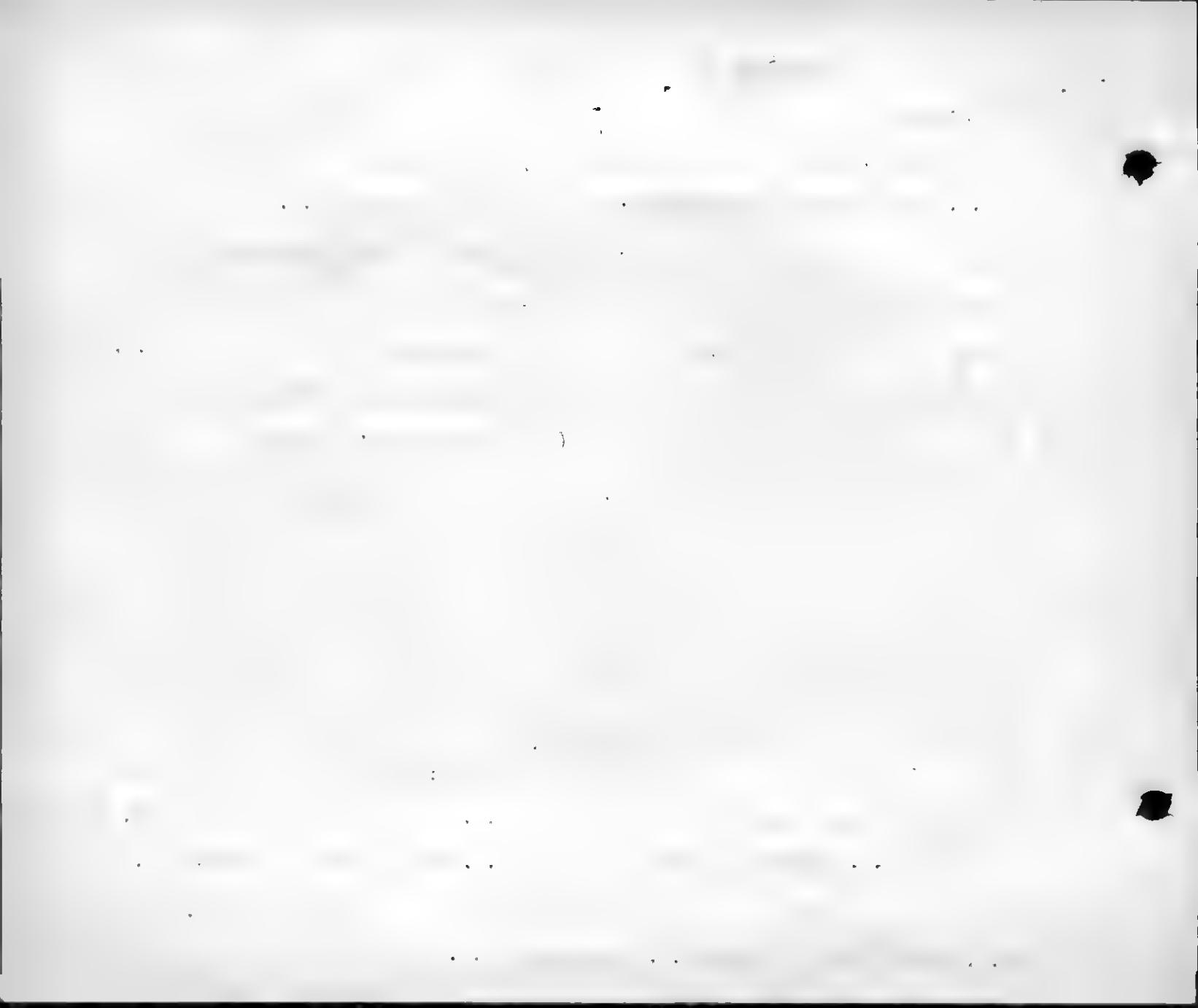
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12752

Reg. Dist. No. 215

| | | | | | |
|---|----------------------------------|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE District of Columbia | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 3 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md. | | | | d. STREET ADDRESS 1108 "I" Street S.E. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) | First Michael | Middle Anthony | Last KEYS | 4. DATE OF DEATH November 24 1959 | Month Day Year |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH 11-21-59 | 9. AGE (in years last birthday) yrs 3 | 10. IF UNDER 1 YEAR Months 3 Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Lawrence KEYS | | | 14. MOTHER'S MAIDEN NAME Alyce Esonia DEWITT | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO None | | INFORMANT (Official Hospital Records) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 DUE TO Congenital Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Tricuspid DUE TO (c) _____ | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 21 November, 1959 , to 24 November, 1959 , that I last saw the deceased alive on 24 November, 1959 , and that death occurred at 2:35 AM , from the causes and on the date stated above. ACTUAL SIGNATURE F. W. Grelo ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 11-24-59 | | | | | |
| PHYSICIAN'S NAME (Type) F. W. GRELLO LT MC USN U.S. Naval Hospital, Bethesda Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11-30-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Arlington National | |
| 22d. LOCATION (City, town, or county) Arlington Va. | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W.H. BACON ADDRESS 1722 7th Street N.W. Washington, D.C. 24a. REC'D BY REGISTRAR DATE NOV 27 '59 24b. REGISTRAR'S SIGNATURE Cathleen L. Thomas | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12753

**FOR STATE
HEALTH DEPT.**

Reg. Dist. No.

| | | | | |
|--|--|--|---|---|
| 12699 | | | | |
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) MARYLAND |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE | | c. LENGTH OF STAY IN 1b | | b. COUNTY MONTGOMERY |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2006 Rockland Avenue | | d. STREET ADDRESS 2006 Rockland Avenue | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE 26 |
| 3. NAME OF DECEASED (Type or print) WARREN | | First PATRICK | Middle KILEY | 4. DATE OF DEATH Month November Day 22 , Year 19 59 |
| 5. SEX Male | | 6 COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH 3/18/11 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Scientist | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't. | | 11. BIRTHPLACE (State or foreign country) Michigan |
| 13. FATHER'S NAME John Kiley | | 14. MOTHER'S MAIDEN NAME Gertrude Smith | | 12. CITIZEN OF WHAT COUNTRY? US |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO 578-07-3578 | | 17. INFORMANT Mrs Eleanor H. Kiley- Item # 2 |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | DUE TO <i>Coronary occlusion</i> | | INTERVAL BETWEEN ONSET AND DEATH Sudden |
| Conditions, If any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. 420.1 | | DUE TO History of previous heart disease | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Natural causes</i> | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i> | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <i>11-23-59</i> | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | | |
| 22a. BURIAL CREMATION: DATE THEREOF REMOVAL (Specify) Burial 11-25-59 | 22c. NAME OF CEMETERY OR CREMATORIUM Mt. Hope | | 22d. LOCATION (City, town, or county) (State) Village Green, Penn. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home 1331 E. Montgomery Ave, Rockville, Md. | ADDRESS | | 24a. REC'D BY REGISTRAR NOV 24 '59 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

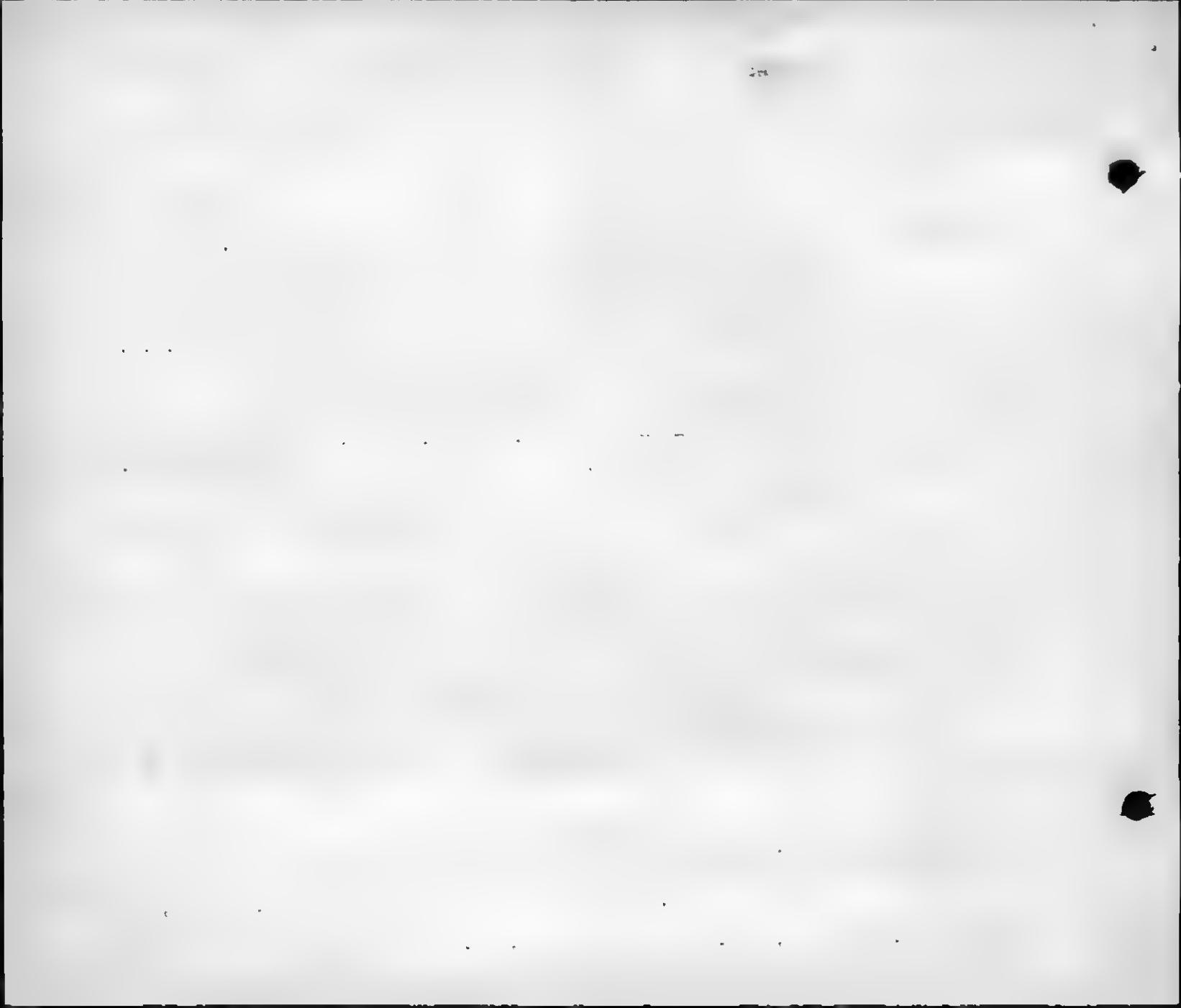
CERTIFICATE OF DEATH

Reg. Dist. No. 12754

| | | | | | | | |
|---|----------------------------------|---|--|--|---------------------------------------|---|----------------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | 19785 MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND | | b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | c. LENGTH OF STAY IN lb 23 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | d. STREET ADDRESS 11430 Maple View Drive | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11430 Maple View Drive | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First FRED | Middle HEINRICH | Last KUNDT | 4. DATE OF DEATH | Month NOV. | Day 24 | Year 19 59 |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/5/84 | 9. AGE (In years less birthday) 74 yrs | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS Days 0 | Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance man | | 10b. KIND OF BUSINESS OR INDUSTRY Haines Lithograph | | 11. BIRTHPLACE (State or foreign country) Germany | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME AUGUST KUNDT | | | 14. MOTHER'S MAIDEN NAME unknown | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 214-12-7635 | | 17. INFORMANT Mrs. Erna M. Kundt, 11430 Maple View Drive | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 15%X | | DUE TO Carcinoma of Pancreas | | Silver Spring, MD | | INTERVAL BETWEEN ONSET AND DEATH 4 months | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. Metastase to Liver | | (b) DUE TO Metastase to Liver | | | | | |
| (c) DUE TO Metastase to Liver | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 7/20/59 , 19_____, to 11/24/59 , 19_____, that I last saw the deceased alive on 11/24/59 , 19_____, and that death occurred at 8 A.M. from the causes and on the date stated above. | | | | ADDRESS (Street, city or town, state) | | DATE SIGNED | |
| ACTUAL SIGNATURE <i>John J. Curry</i> | | N.D. | | 10620 Georgia Lane | | 11/24/59 | |
| PHYSICIAN'S NAME (Type) JOHN J. CURRY | | Silver Spring, Md | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION | | 22b. DATE THEREOF 11/24/59 | | 22c. NAME OF CEMETERY OR CREMATORIAL FT. LINCOLN CREMATORIAL | | 22d. LOCATION (City, town or county) PRINCE GEO. COUNTY, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. <i>Raymond A. Zealor</i> | | ADDRESS SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR NOV 25 '59 | | 24b. REGISTRAR'S SIGNATURE Charles S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Filed 252 11-16-59 et

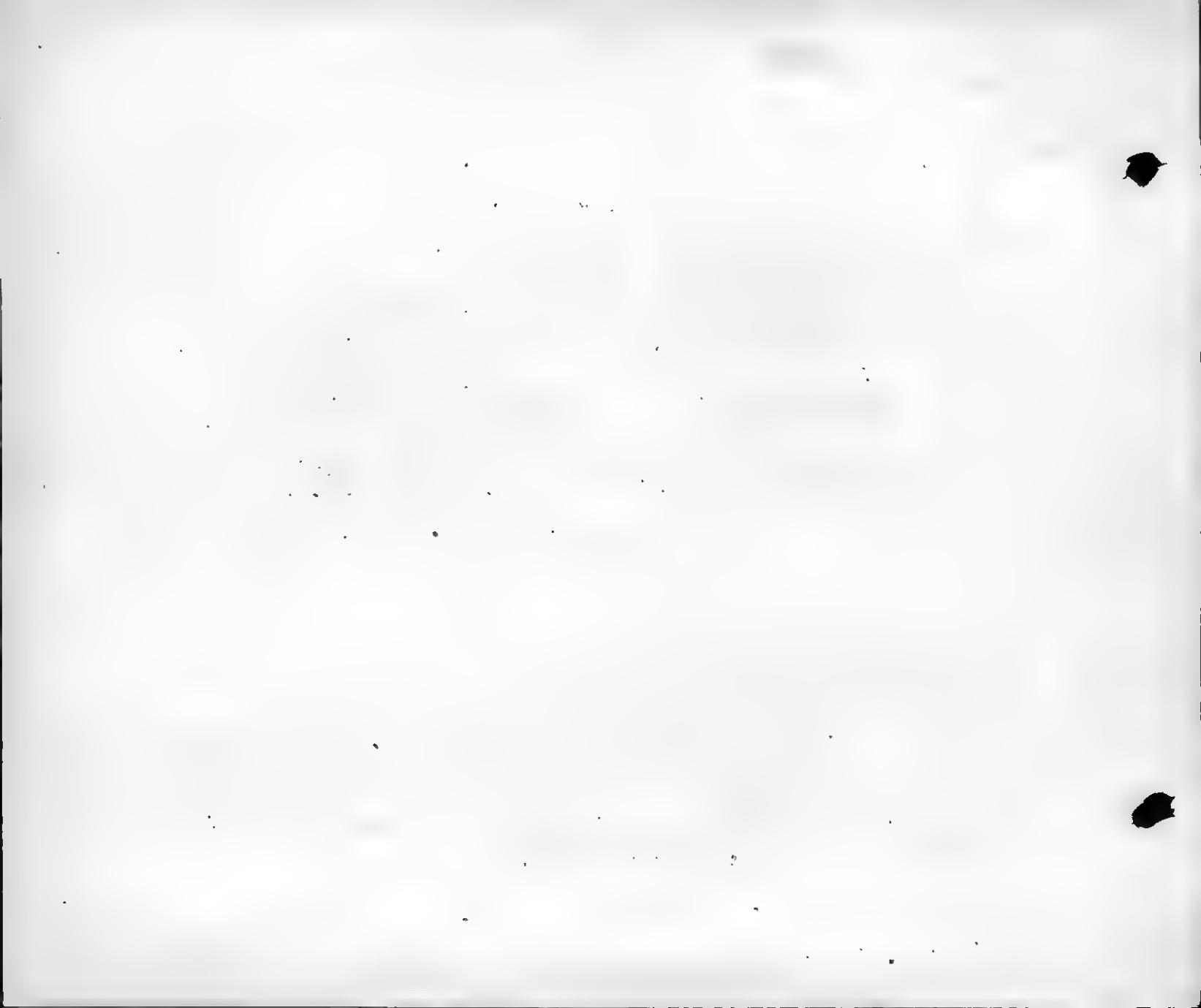
12755

12679

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | |
|--|--|---|---|--|---|--|-------------------------------------|----------------------|------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <i>Maryland</i> | | b. COUNTY <i>Montgomery</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tikona Park</i> | | c. LENGTH OF STAY IN 1b <i>Middle</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> | | d. STREET ADDRESS <i>5419 Queen Anne's Drive</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium Hospital</i> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First <i>John</i> | Middle <i>W.</i> | Last <i>Smith</i> | 4. DATE OF DEATH <i>Nov 7 1959</i> | Month <i>Nov</i> | Day <i>7</i> | Year <i>1959</i> | |
| 5. SEX <i>Male</i> | | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>June 4 1866</i> | 9. AGE (in years last birthday) <i>93 yrs.</i> | IF UNDER 1 YEAR Months <i>0</i> | IF UNDER 24 HRS Days <i>0</i> | Hours <i>0</i> | Min. <i>0</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laundry man</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Laundry business</i> | | 11. BIRTHPLACE (State or foreign country) <i>Novia, S. Africa</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | |
| 13. FATHER'S NAME <i>Unknown</i> | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>123-45-6789</i> | | INFORMANT <i>Washington San + Hosp.太平间, Md.</i> | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>5410</i> | | DUE TO <i>Intestinal obstruction</i> | | | | INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i> | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>Quoddenal peptic ulcer</i> | | (b) DUE TO | | | | | | | |
| (c) | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D. 3131 16TH ST. N.W. WASH. D.C. 147159</i> | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <i>10-20</i> , 19 <i>59</i> to <i>11-7</i> , 19 <i>59</i> that I last saw the deceased alive on <i>11-6</i> , 19 <i>59</i> , and that death occurred at <i>9:00 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Stanley M. Silverberg, M.D.</i> DATE SIGNED <i>11/10/59</i> | | | | | | | | | |
| ACTUAL SIGNATURE <i>Stanley M. Silverberg</i> | | 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | | | | | | |
| PHYSICIAN'S NAME (Type) <i>STANLEY M. SILVERBERG, M.D.</i> | | 22b. DATE THEREOF <i>Nov 10, 1959</i> | | 22c. NAME OF CEMETERY OR CREMATORIAL <i>Woodlawn Cemetery</i> | | 22d. LOCATION (City, town, or county) <i>Forest Glen, Md.</i> | | (State) <i>MD</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>D. S. Hartman</i> | | ADDRESS <i>5732 Ga Ave</i> | | 24a. REC'D BY REGISTRAR DATE <i>NOV 10 '59</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knob</i> | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12756

12786 CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | |
|--|----------------------------------|---|--|--|---|---|-------------------------------------|----------------------|------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived - If institut on Residence before admission) a. STATE District of Columbia | | | | | |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN lb 4 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. | | d. STREET ADDRESS Breighton Hotel | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md. | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Belle Heath | | First | Middle | Last | 4. DATE OF DEATH LEE | Month November | Day 21 | Year 19 59 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-27-86 | 9. AGE (In years last birthday) 73 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS Days 0 | Hours 0 | Min. 0 |
| 10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 13. FATHER'S NAME James E. Heath | | 14. MOTHER'S MAIDEN NAME Virginia UNKNOWN | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | INFORMANT (Husband) Sydney S. Lee | | Address Same as #2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident INTERVAL BETWEEN ONSET AND DEATH 55IX 1 hour | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), slating the under- lying cause lost. (b) DUE TO (c) DUE TO | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) ADDRESS (Street, city or town, state) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 17 November, 1959 , to 21 November, 1959 , that I last saw the deceased alive on 21 November, 1959 , and that death occurred at 5:45 PM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>John L. Royal Lt (act) usn</i> ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 11-22-59 | | | | | | | | | |
| PHYSICIAN'S NAME (Type) P. L. ROYAL LT MC USN | | U.S. Naval Hospital, Bethesda Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11-24-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Arlington National | | 22d. LOCATION (City, town, or county) Arlington Va. | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Gawlers & Sons</i> | | ADDRESS 1756 Penn. Ave. N.W. Washington | | 24a. REC'D BY REGISTRAR Nov. 25 '59 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12680

CERTIFICATE OF DEATH

Reg. Dist. No.

12757

| | | | | | | | | | |
|--|------------------------------|--|-----------------------------------|---|--|--|--|--|--|
| 1 PLACE OF DEATH COUNTY MONTGOMERY | | MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND | | b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK | | c. LENGTH OF STAY IN 1b • | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | d. STREET ADDRESS 10805 E NOKREST DR | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. SAV. & Hospital | | | | d. STREET ADDRESS 10805 E NOKREST DR | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print) LeIBOWITZ, Mr. REUBEN | | 4. DATE OF DEATH MMN | | Month 11 | | Day 4 | | Year 1959 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH 8-8-11 | 9. AGE (In years lost birthday) 68 yrs. | | 10. IF UNDER 1 YEAR Months 0 | | 11. IF UNDER 24 HRS., Months 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PATENT EXAMINER | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT. | | 11. BIRTHPLACE (State or foreign country) Brooklyn, NEW YORK | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 13. FATHER'S NAME LeIBOWITZ, Mr. William | | 14. MOTHER'S MAIDEN NAME B. Pearlman, I.D.A. | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 074-00-0000 | | 17. INFORMANT LeIBOWITZ, Mrs. Betty Nokrest Dr. S.S/N | | Address 10805 E NOKREST DR, SILVER SPRING, MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 | | DUE TO MYOCARDIAL INFARCTION | | INTERVAL BETWEEN ONSET AND DEATH MOMENTS | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO HYPERTENSIVE (CARDIOVASCULAR DISEASE) | | (c) RENAL DISEASE | | YEARS | | | | | |
| Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) SILVER SPRING | | (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19_____, to PRESENT , 19_____, that I last saw the deceased alive on _____, 11-2-1959, and that death occurred at 8:11 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Abraham W. Danish</i> | | | | | | ADDRESS (Street, city or town, state) 927 PERSHING DR, SILVER SPRING, MD. | | DATE SIGNED 11-4-59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 11/6/1959 | | 22c. NAME OF CEMETERY OR CREMATORIUM GEO CEMET. CO. LTD. | | 22d. LOCATION (City/Town, or county) Hyattsville, Md. | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Goldberg Funeral Home 4/17-Edgar</i> | | ADDRESS 4/17-Edgar | | 24a. REC'D BY REGISTRAR MM 6 1959 | | 24b. REGISTRAR'S SIGNATURE <i>Edgar</i> | | | |



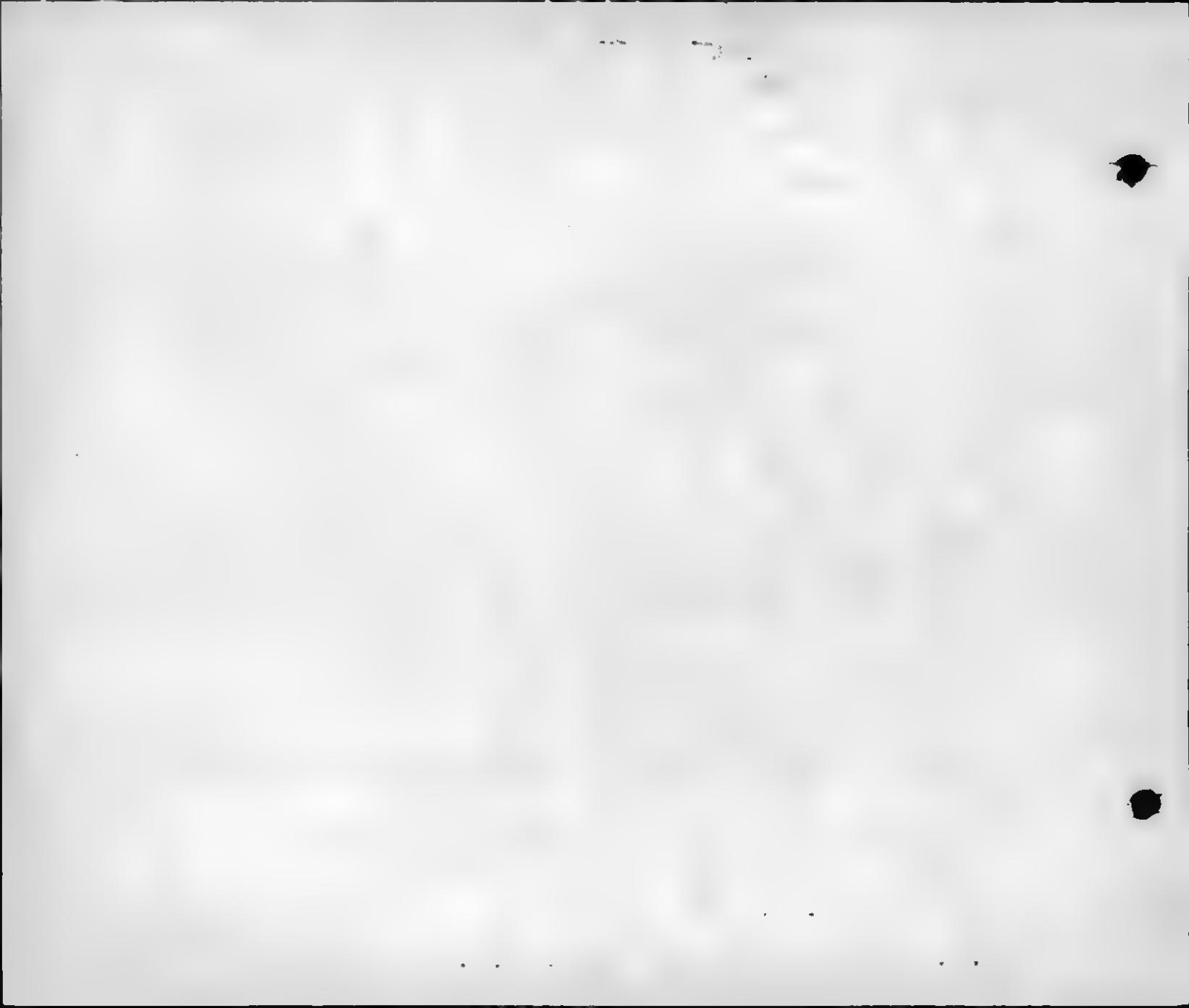
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12758

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Fill in Items 1 and 2 with the registrar prior to burial, cremation, or removal.

| | | | | | | | | |
|---|--|--|---|---|---------------|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. LENGTH OF STAY IN 1b <u>5 years</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | d. STREET ADDRESS <u>2307 Westview Dr</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2307 Westview Dr</u> | | | | d. DATE OF DEATH <u>Nov 16</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) <u>Thomas</u> | | First <u>T</u> | Middle <u>esaris</u> | Last <u></u> | Month <u></u> | Day <u></u> | Year <u>1959</u> | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-9-1887</u> | | 9. AGE (in years last birthday) <u>72 yrs.</u> | IF UNDER 1 YEAR <u></u> Months <u></u> Days <u></u> | IF UNDER 24 HRS. <u></u> Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Italy</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>A.S.A.</u> | | |
| 13. FATHER'S NAME <u>Peter Lerasis</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Jane De Marinis</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u></u> | | | | |
| 17. INFORMANT <u>Peter Lerasis (son)</u> Address <u>2711 Newton St Silver Spring MD</u> | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4</u> DUE TO <u>Coronary occlusion</u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u> | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Blaschak</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED <u>Nov 16-1959</u> | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Blaschak Jr</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Nov. 18, 1959</u> | | 22c. NAME OF CEMETERY OR CREMATORIAL <u>Fort Lincoln Cem</u> | | 22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co Maryland</u> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. K. Huntemann & son</u> | | | | ADDRESS <u>5732 Georgia Ave N. W.</u> | | 24a. REC'D BY REGISTRAR <u>NOV 18 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knapp</u> | | |
| | | | | | | DATE | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item

13/33 1WK

12788

CERTIFICATE OF DEATH

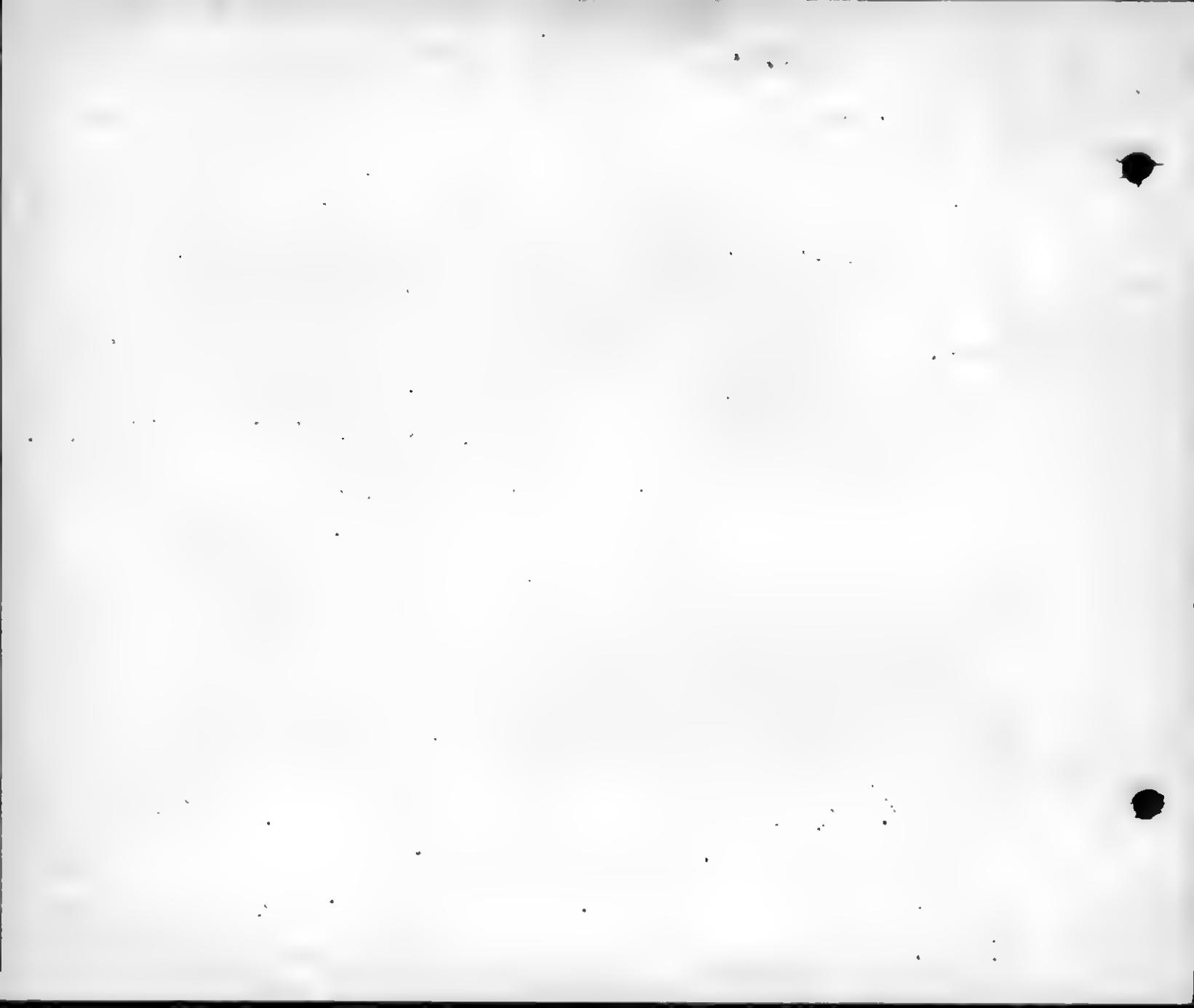
Reg. Dist. No.

12759

TO HOSPITAL OR CLINIC: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

| | | | | | | | | |
|--|--|---|---|--|--|--|-------------------------|-----------|
| 1. PLACE OF DEATH a. COUNTY <i>Mont. Co.</i> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> | | b. COUNTY <i>Montgomery</i> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington, Md.</i> | | d. STREET ADDRESS Res. <i>4700 Cathedral Ave. W. Washington, D.C.</i> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kensington Gardens San.</i> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) <i>Jennie</i> | | First | Middle | Last | 4. DATE OF DEATH <i>Lay</i> | Month | Day | Year |
| 5. SEX <i>F</i> | | 6 COLOR OR RACE <i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH <i>2/15/89</i> | 9 AGE (In years last birthday) <i>70 yrs.</i> | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Days | Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>--</i> | | 11. BIRTHPLACE (State or foreign country) <i>Ireland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | |
| 13. FATHER'S NAME <i>Philip Bernton</i> | | 14. MOTHER'S MAIDEN NAME <i>Rose Davidson</i> | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>Unknown</i> | | INFORMANT <i>Washington D. C. Address</i> Brother <i>Harry S. Bernton-4000 Cathedral Ave. N.W.</i> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic adenocarcinoma of colon</i> | | | | | | | | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first (b) <i>Metastases in liver, lungs, lymph nodes, bone marrow</i> | | | | | | | | |
| DUE TO (c) <i>Bronchopneumonia</i> | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | |
| 19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from <i>10-15</i> to <i>11-25</i> , 1959, that I last saw the deceased alive on <i>11-23</i> , 1959, and that death occurred at <i>1130A.M.</i> from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) <i>1051 Summit Ave</i> DATE SIGNED <i>George Sharpe</i> | | | | | | |
| ACTUAL SIGNATURE <i>George Sharpe</i> | | M.D. <i>George Sharpe</i> | | | | | | |
| PHYSICIAN'S NAME (Type) <i>George Sharpe</i> | | Kensington, Md 11-25-59 | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>11-30-59</i> | | 22c. NAME OF CEMETERY OR CREMATORIUM <i>Watertield Cemetery</i> | | 22d. LOCATION (City, town, or county) <i>Middlesex Co. Mass.</i> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Romphrey</i> | | ADDRESS <i>7557 Wisc. Ave. Both</i> | | 24a. REC'D BY REGISTRAR DATE <i>NOV 30 '59</i> | | 24b. REGISTRAR'S SIGNATURE <i>Orinus S. Thorne</i> | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12760

12681

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE

D.C.

b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN lb
less than

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Washington Sanitarium

1 hr.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Washington

d. STREET ADDRESS

813 Ingraham St. N.W.

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

November 30

19 59

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
lost birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

male

white

WIDOWED DIVORCED

12/17/1885

Months

Days

Hours

Min

73

yrs

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Retired Cabinet maker, white House

Virginia

U.S.A.

13. FATHER'S NAME

David Lewis

14. MOTHER'S MAIDEN NAME

Matilda Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO

587-52-2353

INFORMANT

Address Bethesda, Md.
Richard L. Stakes, 5505 Glenwood Rd.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Cerebrovascular

INTERVAL BETWEEN
ONSET AND DEATH

12 months

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Coronary of colon

15 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

None

19. WAS AUTOPSY
PERFORMED?
YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

None

20c. TIME OF INJURY Month, Day, Year
Hour o. m. — 19
p. m.20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 10/17/58, to 11/130, 1959, that I last saw the deceased alive on 11/27/58, 1959, and that death occurred at M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

John B. Umhoe

M.D.

8805 Conn. Ave.

11/28/58

PHYSICIAN'S
NAME (Type)

John B. Umhoe

Chevy Chase 15 Md

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

12/3/59

22c. NAME OF CEMETERY OR CREMATORI

Cem. Bethany Baptist Church

22d. LOCATION (City, town, or county)

(State)

Callao, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE

The S.H. Hines Co., 2901 14th St. N.W.,

Wash. D.C.

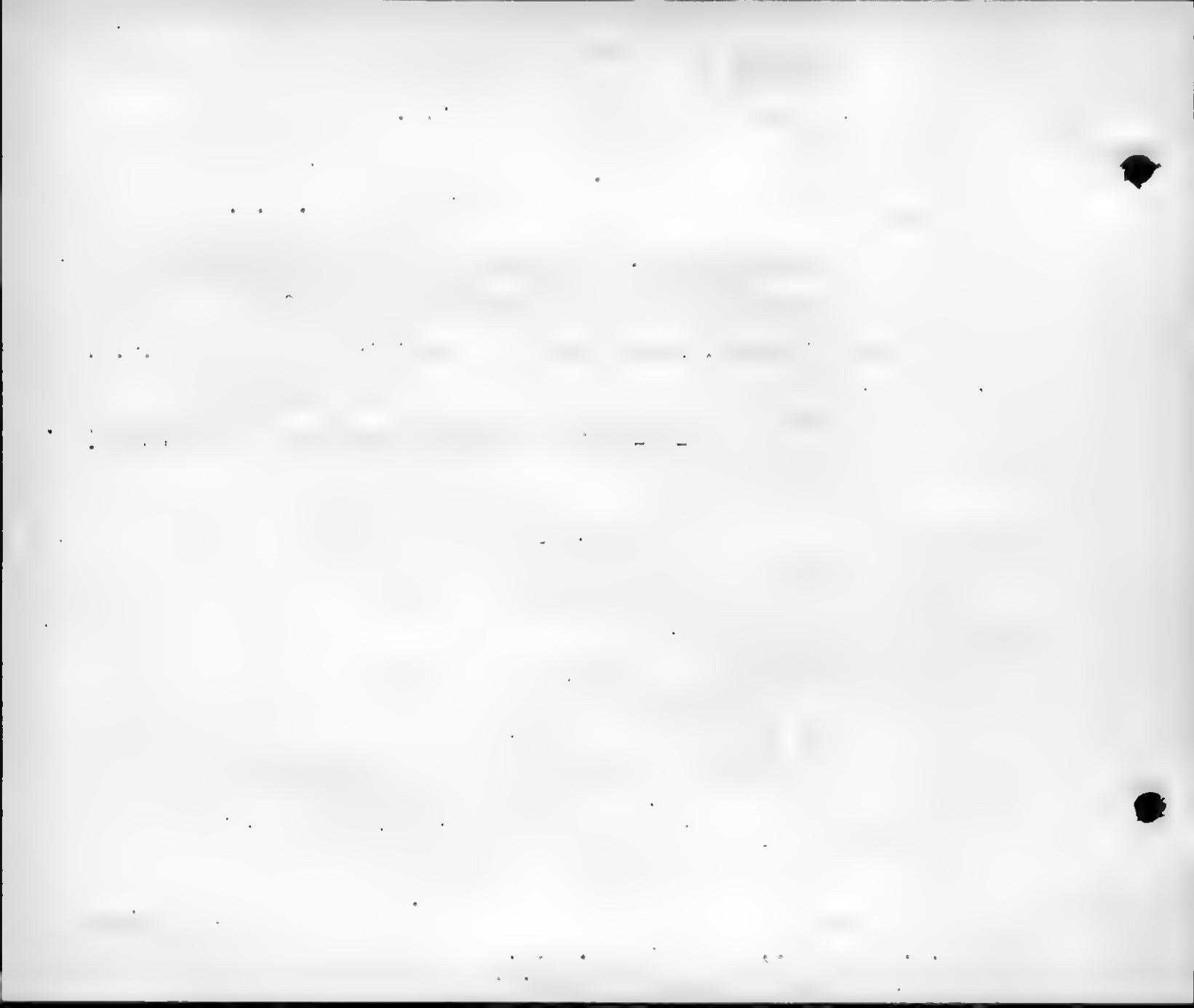
Wash., D.C.

24a. REC'D BY REGISTRAR

DEC 1 '59

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12761

| | | | | | | |
|---|--|---|--|--|--|-------------|
| 1. PLACE OF DEATH a. COUNTY | | 12682 | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) ✓ | | |
| Montgomery | | MARYLAND | | a. STATE | Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | | b. COUNTY | Prince Georges Co. | |
| Takoma Park | | DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| Washington San & Hospital | | 7502 Wells Blvd. | | | | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle | Last | 4. DATE OF DEATH | |
| William | | Jay | | Lewis | NOV. 27 1959 | |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | |
| Male | | White | | June 25, 1894 | 65 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | |
| Optometrist | | | | Poltava | UKRAINE | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Joseph Rubin | | Miriam Sklorsky | | U.S.A. | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yn, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | |
| Yes I.W.W.I | | 579-01-7937 | | Doralee Lewis | 7502 Wells Blvd | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | Address | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| Heart disease | | Sudden | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | DUE TO | | | | |
| (b) | | | | | | |
| DUE TO | | | | | | |
| (c) | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | |
| ACTUAL SIGNATURE | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED |
| EXAMINER'S NAME (Type) | | Frank J. Broschart | | | | 11-27-59 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) | (State) |
| BURIAL | | DEC. 2, 1959 | ARLINGTON NATIONAL CEM. | | ARLINGTON - Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | |
| B. DANZANSKY & SONS - 3501 - 14th Street | | | DATE DEC 1 '59 | | Clintha S. Krause | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12762

12789

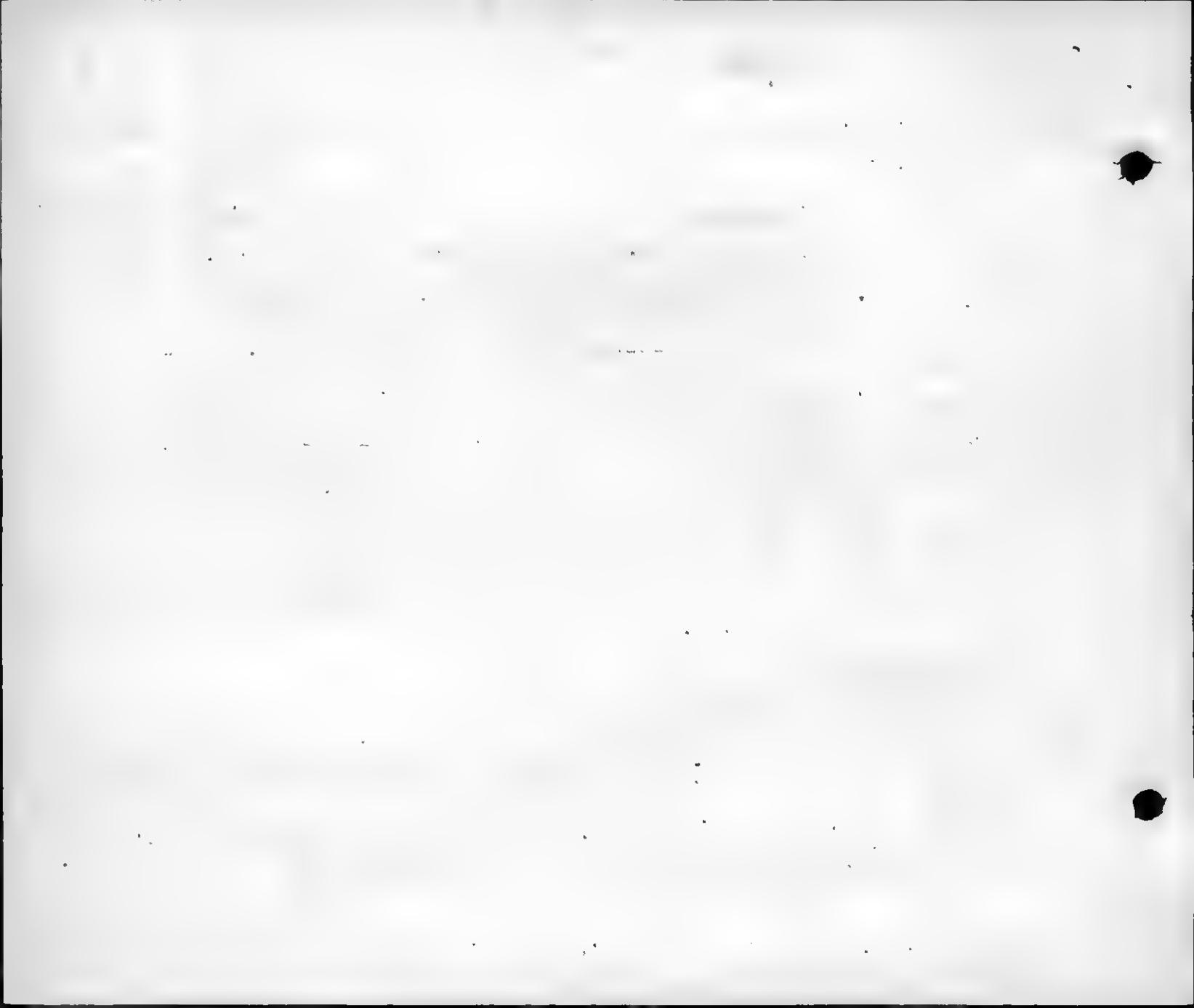
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|---------------------------------|---|--------------------------------------|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | d. STREET ADDRESS 4610 Chase Avenue | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4610 Chase Avenue | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) NORA HUNTER LOGAN | | First | Middle | Last | 4. DATE OF DEATH Month Nov. | Day 9 | Year 19 59 |
| S SEX Female | 6 COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/11/1868 | 9. AGE (In years last birthday) 91 yrs | 10. IF UNDER 1 YEAR Moths 7 | 11. IF UNDER 24 HRS. Days 28 | 12. Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) Washington, D. C | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME George Gartrell | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO None | | INFORMANT William Logan-son-same as 2d | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized + Central Arteriosclerosis</i> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <i>Malnutrition</i> INTERVAL BETWEEN ONSET AND DEATH • 20 yrs • | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----- | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. ----- | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----- | | 20f. (City or town) (County) (State) ----- | |
| 21. I certify that I attended the deceased from 11/19/55 , 19 to 11/9/59 , 19 that I last saw the deceased alive on 11/9/59 , and that death occurred on 9/15/59 from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 9300 Ewing Drive, Bethesda, Md. DATE SIGNED 11/9/59 | | | | | | | |
| ACTUAL SIGNATURE Seymour Greenbaum | | | | | | | |
| PHYSICIAN'S NAME (Type) Seymour Greenbaum | | 9300 Ewing Drive, Bethesda, Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/11/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Suitland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | | | ADDRESS Bethesda, Maryland | | 24a. REC'D BY REGISTRAR NOV 13 '59 | 24b. REGISTRAR'S SIGNATURE Arthur & Kraus |

TO HOSPITAL OR CLINIC: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12763

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | c. LENGTH OF STAY IN lb 9 years | | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6 MANCHESTER PLACE APT. 101 | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND | | b. COUNTY MONTGOMERY | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | |
| | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First ANNA | | Middle (NMI) | | Last LORENZEN | | 4. DATE OF DEATH NOV. 8 | | Month Day Year Month Day Year | | IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH FEB. 11, 1884 | | 9. AGE (In years last birthday) 75 yr. | | IF UNDER 1 YEAR Months 0 Days 0 | | IF UNDER 24 HRS Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | 11. BIRTHPLACE (State or foreign country) AUSTRIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME UNKNOWN SCHIDTLER | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT WM. F. LORENZEN, 6 MANCHESTER PLACE, SILVER SPRING | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | DUE TO 420.1 | | Coronary occlusion | | INTERVAL BETWEEN ONSET AND DEATH sudden | | | | | |
| | | Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. | | (b) DUE TO | | arterio-sclerotic vascular heart disease | | (c) 2 yrs | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 11-9-59 | | | | | | | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i> | | EXAMINER'S NAME (Type) FRANK J. BROSCHEIT | | 22b. DATE THEREOF 11/12/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM SORDIS CHAPEL CEMETERY | | 22d. LOCATION (City, town, or county) ST. MICHAELS, MARYLAND | | (State) | | | |
| 22e. BURIAL, CREMATION REMOVAL (Specify) BURIAL | | 22f. ADDRESS SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR NOV 13 59 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur E. Koenig</i> | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. POMPHEY, INC. <i>Raymond A. Ziska</i> | | | | | | | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,4 filing 252 11-24-59 et

12764

12791

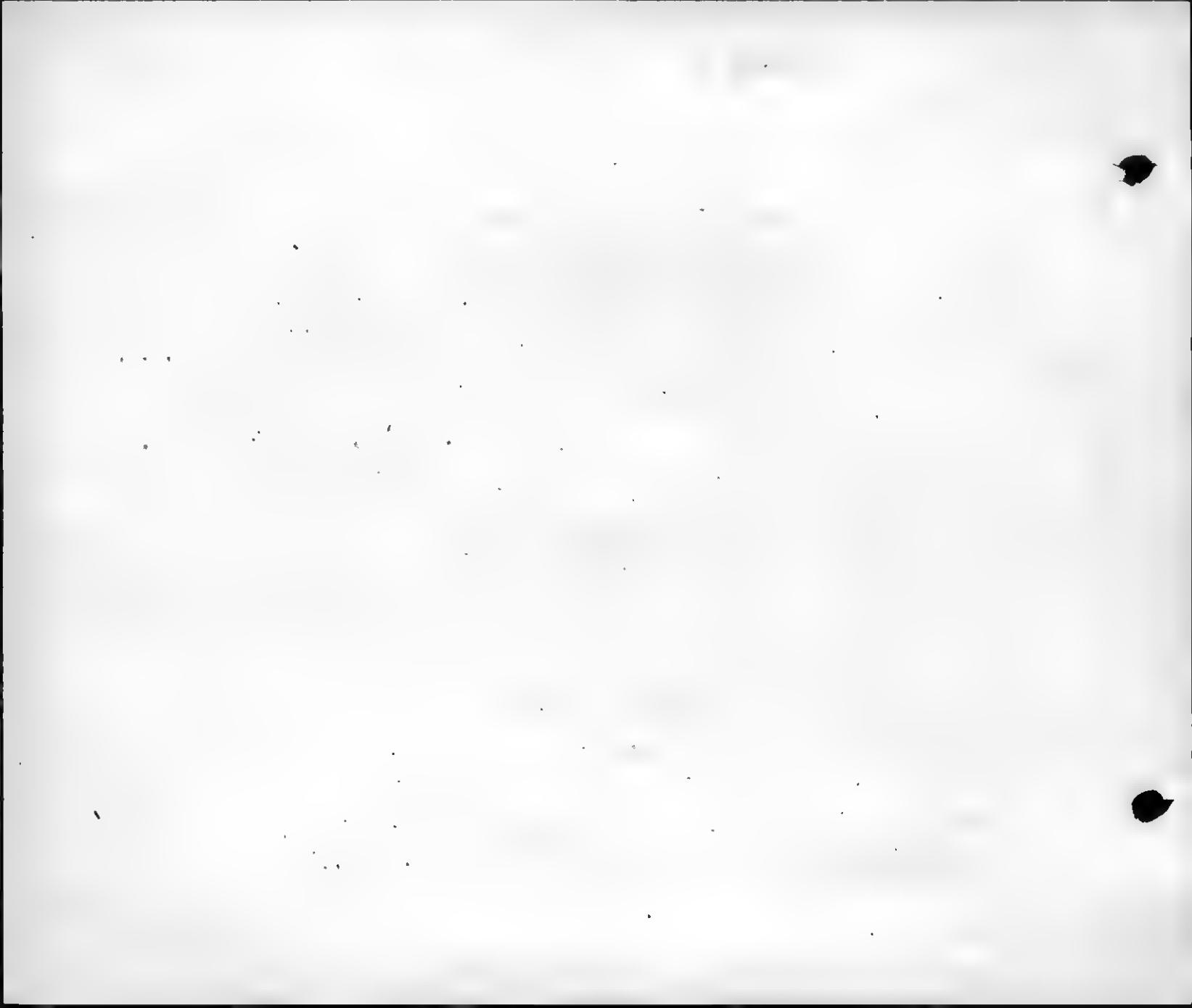
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck | | c. LENGTH OF STAY IN 1b Life time | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bradford Nursing Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First William | Middle Fenmore | Last Lynn |
| 4. DATE OF DEATH | Month 11 | Day 14 | Year 1959 |
| 5. SEX Male | 6. COLOR OR RACE Col | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH April 4 1902 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Manufactured | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph Lynn | | 14. MOTHER'S MAIDEN NAME Mary Carter | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. INFORMANT Nellie L. Bishop, Sandy Spring, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture Cerebral Artery DUE TO 330X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) Aneurysm DUE TO (c) Vascular Sclerosis | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 5, 1959 to Nov. 7, 1959 , that I last saw the deceased alive on Nov. 7, 1959 and that death occurred at 4:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) WEBSTER SENELL M.D. Rt. 1, Silver Spring ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) WEBSTER SENELL Norbeck DATE SIGNED 11-16-59 | | | |
| 22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/17/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Ash Memorial Cemetery | | 22d. LOCATION (City, town, or county) Sandy Springs (State) Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Snowden - Rockville, Md. | | 24a. REC'D BY REGISTRAR NOV 19 1959 DATE | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12765

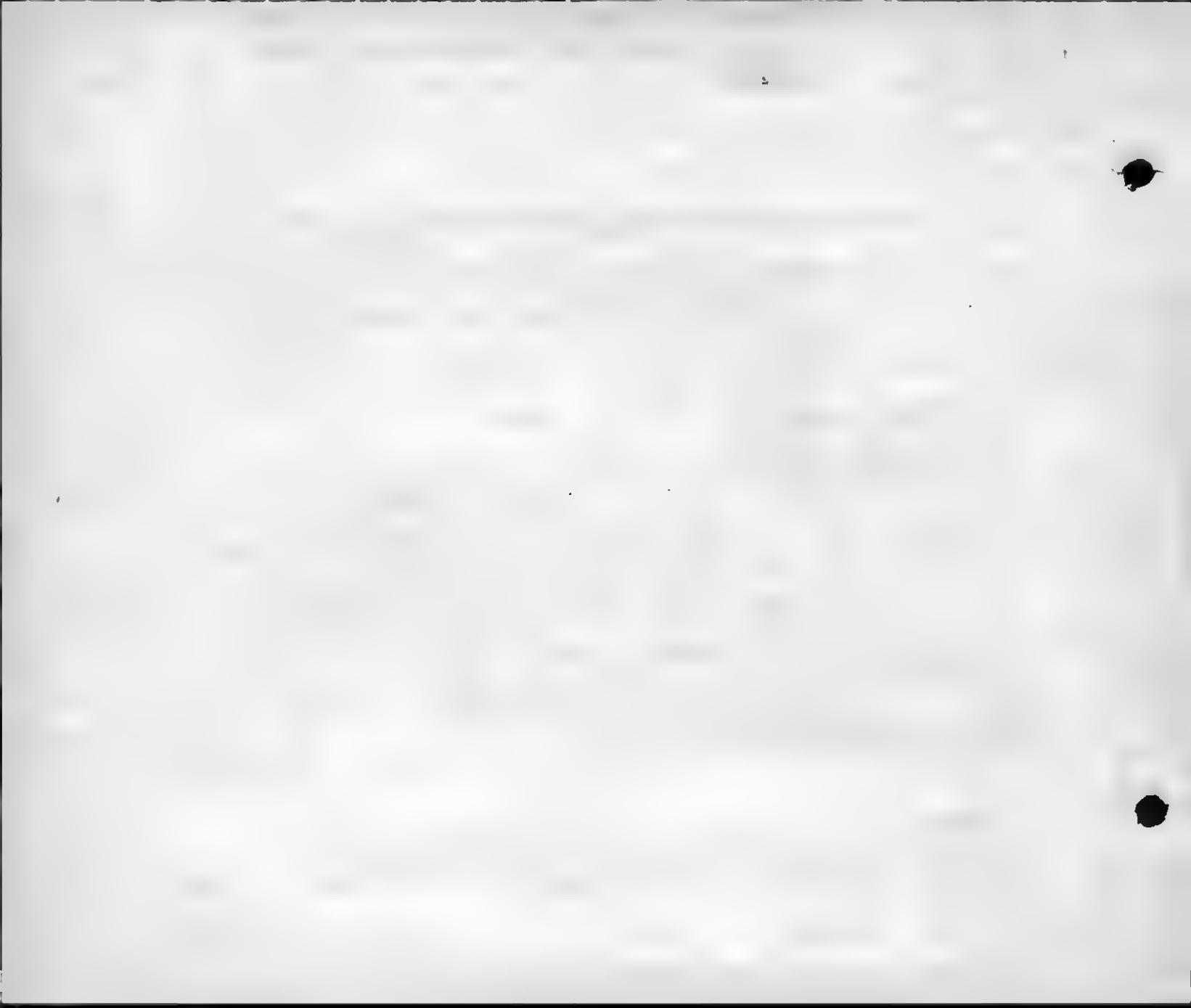
Reg. Dist. No.

12683

| | | | | | |
|--|---|---|---|----------------------------|-------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | | b. COUNTY <i>Montgomery</i> | | | |
| c. LENGTH OF STAY IN lb <i>57 hrs.</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington San. & Hosp.</i> | | d. STREET ADDRESS <i>709 FORSTON DR.</i> | | | |
| e. IS PERSON ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) | First <i>Regina</i> | Middle <i>Mary</i> | Last <i>McIntosh</i> | | |
| 4. DATE OF DEATH | Month <i>Nov</i> | Day <i>21</i> | Year <i>1959</i> | | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH <i>3-13-1922</i> | | |
| 9. AGE (in years last birthday) <i>39 yrs.</i> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | 10b. KIND OF BUSINESS OR INDUSTRY <i>—</i> | 11. BIRTHPLACE (State or foreign country) <i>Pa</i> | | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | | |
| 13. FATHER'S NAME <i>Joseph Foley</i> | 14. MOTHER'S MAIDEN NAME <i>CATHERINE McCANN</i> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | 16. SOCIAL SECURITY NO. | 17. INFORMANT | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive subarachnoid hemorrhage</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>3 days plus</i> | | | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral contusions and lacerations</i> | | | | | |
| DUE TO (c) <i>A fall down a flight of stairs</i> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell down stairs at home</i> | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>11-18 1959</i> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i> | 20f. (City or town) <i>Takoma Park</i> | (County) <i>Montgomery</i> | (State) <i>MD</i> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE <i>Frank J. Bloschert</i> | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED <i>11-21-59</i> | | |
| EXAMINER'S NAME (Type) <i>FRANK J. Bloschert</i> | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | 22b. DATE THEREOF <i>Nov. 25, 1959</i> | 22c. NAME OF CEMETERY OR CREMATORIAL <i>ARLINGTON NAT'L</i> | 22d. LOCATION (City, town, or county) <i>ARLINGTON</i> | (State) <i>VA.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>WW Tallon</i> | ADDRESS <i>3603 14th St NW DC</i> | 24a. RECD BY REGISTRAR <i>NOV 23 '59</i> | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



12766

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | c. LENGTH OF STAY IN 1b DOA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hosp. | | e. STREET ADDRESS 8230-14th Ave Hyattsville 161 | |
| 3. NAME OF -DECEASED (Type or print) Clifton | | First Walter | Middle Malcolm |
| Last 100 | | 4. DATE OF DEATH 9-11-59 | Month Sept |
| 5. SEX M | | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9-18-11 |
| 9. AGE (In years last birthday) 48 yrs. | | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS. Days 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Walter A. Malcolm | | 14. MOTHER'S MAIDEN NAME Pamelia Pope. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes, 1941-1946 | | 16. SOCIAL SECURITY NO. 114-67-6654 | |
| 17. INFORMANT Mrs Lauretta Malcolm - wife | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. 420.1 (b) DUE TO (c) | |
| | | INTERVAL BETWEEN ONSET AND DEATH sudden | |
| 19. WAS AUTOPSY PERFORMED? NO | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | |
| 20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Moorefield, Md. (County) Montgomery (State) Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | DATE SIGNED 11-5-59 | |
| EXAMINER'S NAME (Type) FRANK J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 11-8-1959 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM Olivet Cemetery | | 22d. LOCATION (City, town, or county) Moorefield, Md. (State) Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Byron Right Cumberland, Md. | | ADDRESS Chestnut & Hines | 24a. REC'D BY REGISTRAR DATE NOV 9 '59 |
| | | 24b. REGISTRAR'S SIGNATURE | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



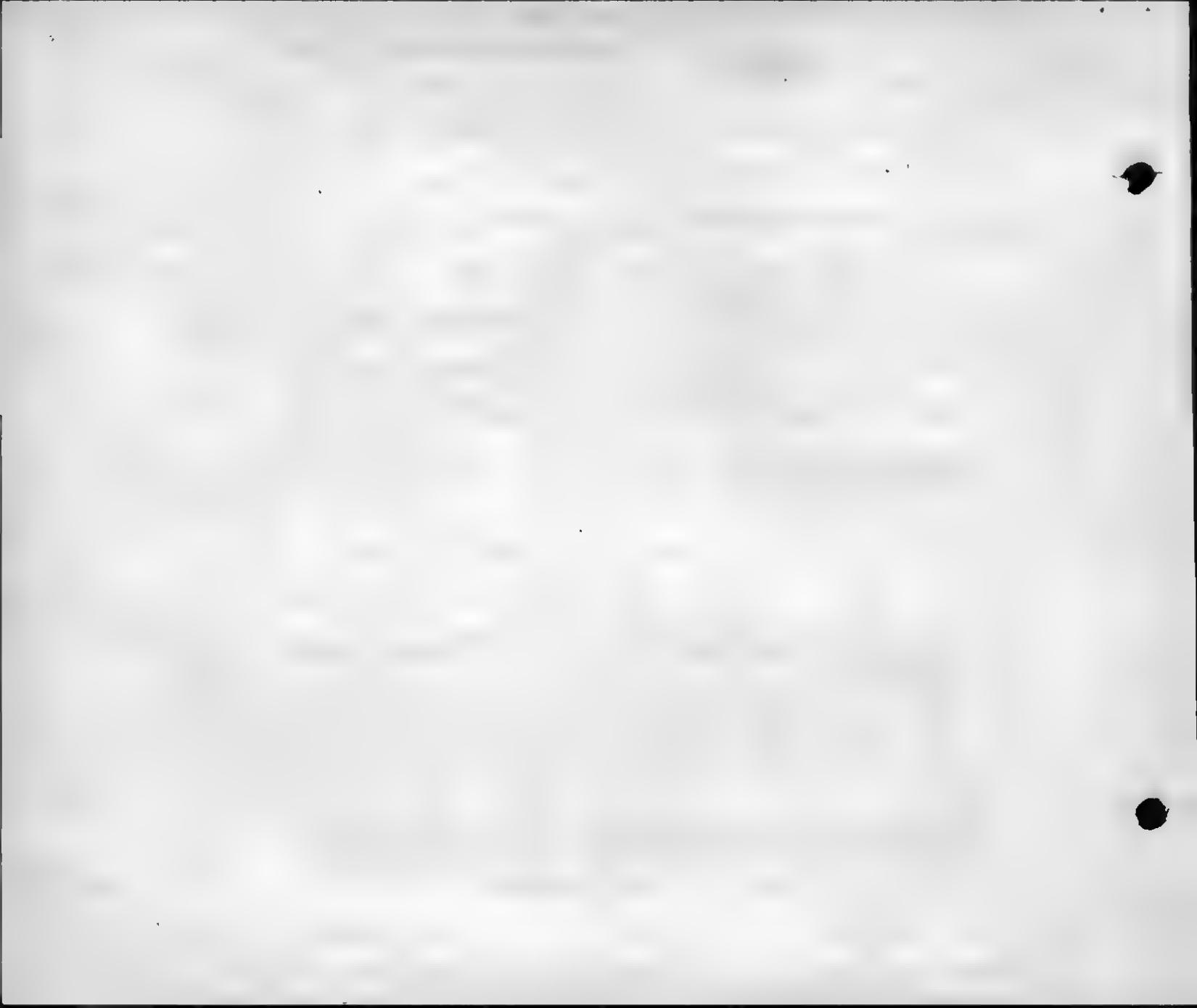
12767

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) | |
| Montgomery MARYLAND | | a. STATE <i>DC</i> | b. COUNTY <i>/</i> |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN lb | |
| <i>Silver Spring 1 wk</i> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS | |
| <i>Hairland Nursing Home</i> | | <i>Washington 410-738 Longfellow N.W.</i> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | First <i>Alice</i> | Middle <i>Martais</i> |
| | | Last <i>Jenelle</i> | 4. DATE OF DEATH Month <i>Nov</i> Day <i>3</i> Year <i>1959</i> |
| 5. SEX <i>Female</i> | | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <i>7-5-1869</i> |
| 9. AGE (In years last birthday) <i>90 yrs.</i> | | 10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> | 11. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>N.Y.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>John Brown WEST</i> | | 14. MOTHER'S MAIDEN NAME <i>Rebecca WEST</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>No</i> | |
| 17. INFORMANT <i>Nursing Home Record</i> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute congestive heart failure</i> DUE TO <i>452.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>(b) Arthritis - Fibroelastitis</i> DUE TO <i>4 weeks</i> (c) | | INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Post operative stranguled hernia 1 mo ago</i> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>1 mo ago</i> | |
| 20c. TIME OF INJURY Hour <i>a. m.</i> <i>p. m.</i> 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) <i>(State)</i> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | DATE SIGNED <i>11-3-59</i> | |
| ACTUAL SIGNATURE <i>Frank J. Boschart</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <i>Frank J. Boschart</i> | | 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i> | |
| 22b. DATE THEREOF <i>11-5-59</i> | | 22c. NAME OF CEMETERY OR CREMATORIUM <i>National Memorial Park</i> | |
| 22d. LOCATION (City, town, or county) <i>Falls Church, Va.</i> | | (State) <i>Vir.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Francis J. Heffernan 3821-1472, N.W. Wash. D.C.</i> | | 24a. REC'D BY REGISTRAR DATE <i>NOV 4 '59</i> | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12768

| | | | | | | | | | |
|---|--|---|----------|---|---------------------------|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 12793 Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md | | b. COUNTY ENTOMAL | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | FAIRLAND | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | Silver Spring | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | Fairland Nursing Home | | d. STREET ADDRESS | | 12422 Littleton St. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First Joseph | Middle M | Last Mayerson | 4. DATE OF DEATH | Month Nov | Day 2 | Year 1959 | |
| 5. SEX m | | 6. COLOR OR RACE w | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/5/1892 | | 9. AGE (In years last birthday) 67 yrs | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Retired office clerk | | | | Thika Pa | | USA | | | |
| 13. FATHER'S NAME Louis Mayerson | | 14. MOTHER'S MAIDEN NAME Dina Frommer | | Address | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. 45-07-9278 | | 17. INFORMANT Victoria Mayerson | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX DUE TO <i>Hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral vascular accident</i> DUE TO <i>Arteriosclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <i>Arteriosclerosis</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>Minutes</i> | |
| 20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED p.m. 19 While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <i>August</i> , 1959, to <i>Sept 2</i> , 1959, that I last saw the deceased alive on <i>Sept 12</i> , 1959, and that death occurred at <i>607 M</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Richard P. Delaney M.D.</i> ADDRESS (Street, city or town, state) <i>4323 Howard St., Oct 2, 1959</i> DATE SIGNED <i>Oct 2, 1959</i> | | | | | | | | | |
| PHYSICIAN'S NAME (Type) <i>Richard P. DELANEY MD</i> | | 22a. FUNERAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>11/3/59</i> | | 22c. NAME OF CEMETERY OR CREMATORIAL <i>Westmead Park</i> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Goldberg Funeral Home Washington</i> | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE <i>NOV 3 '59</i> | | 24b. REGISTRAR'S SIGNATURE | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12794

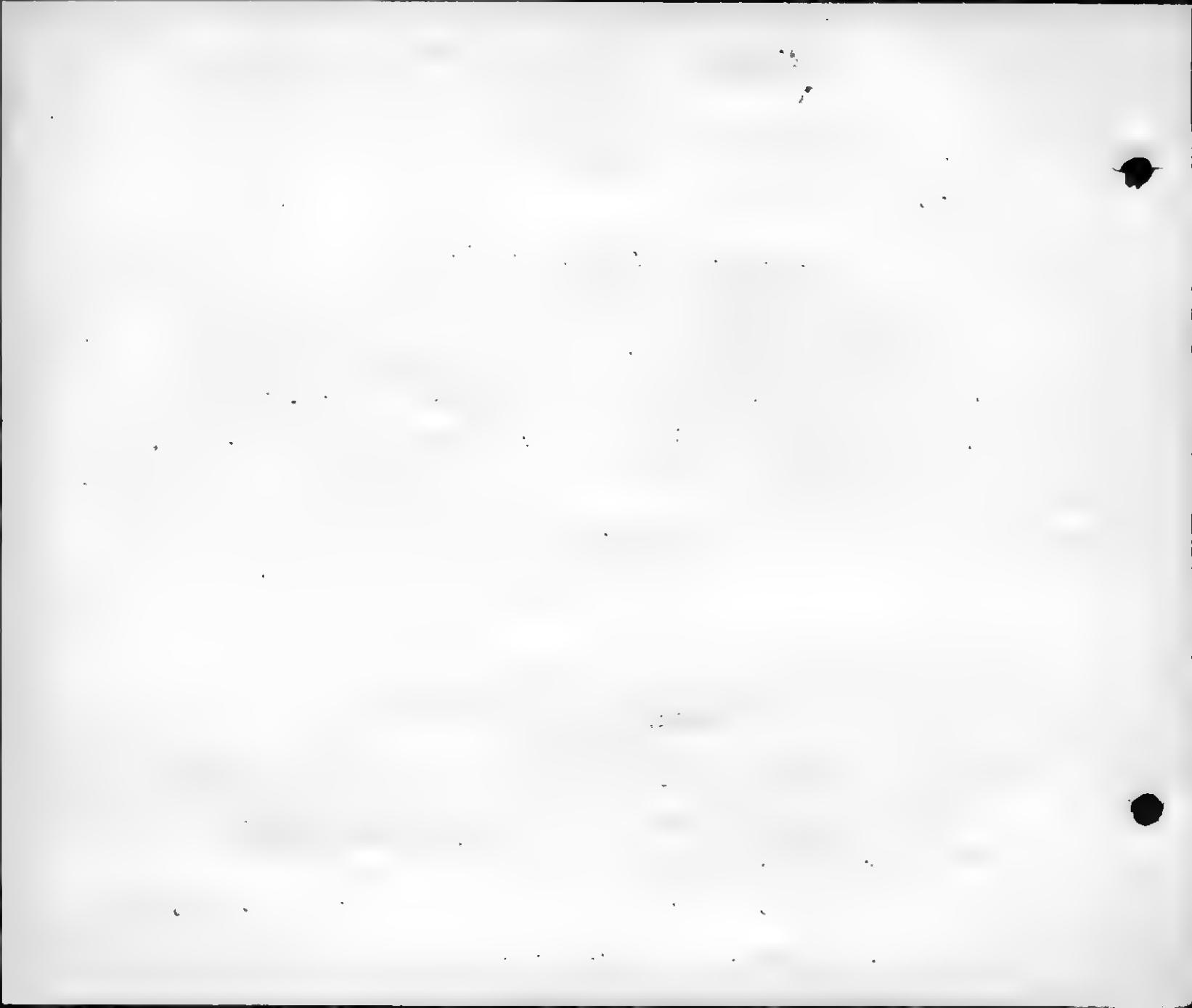
CERTIFICATE OF DEATH

Reg. Dist. No.

12769

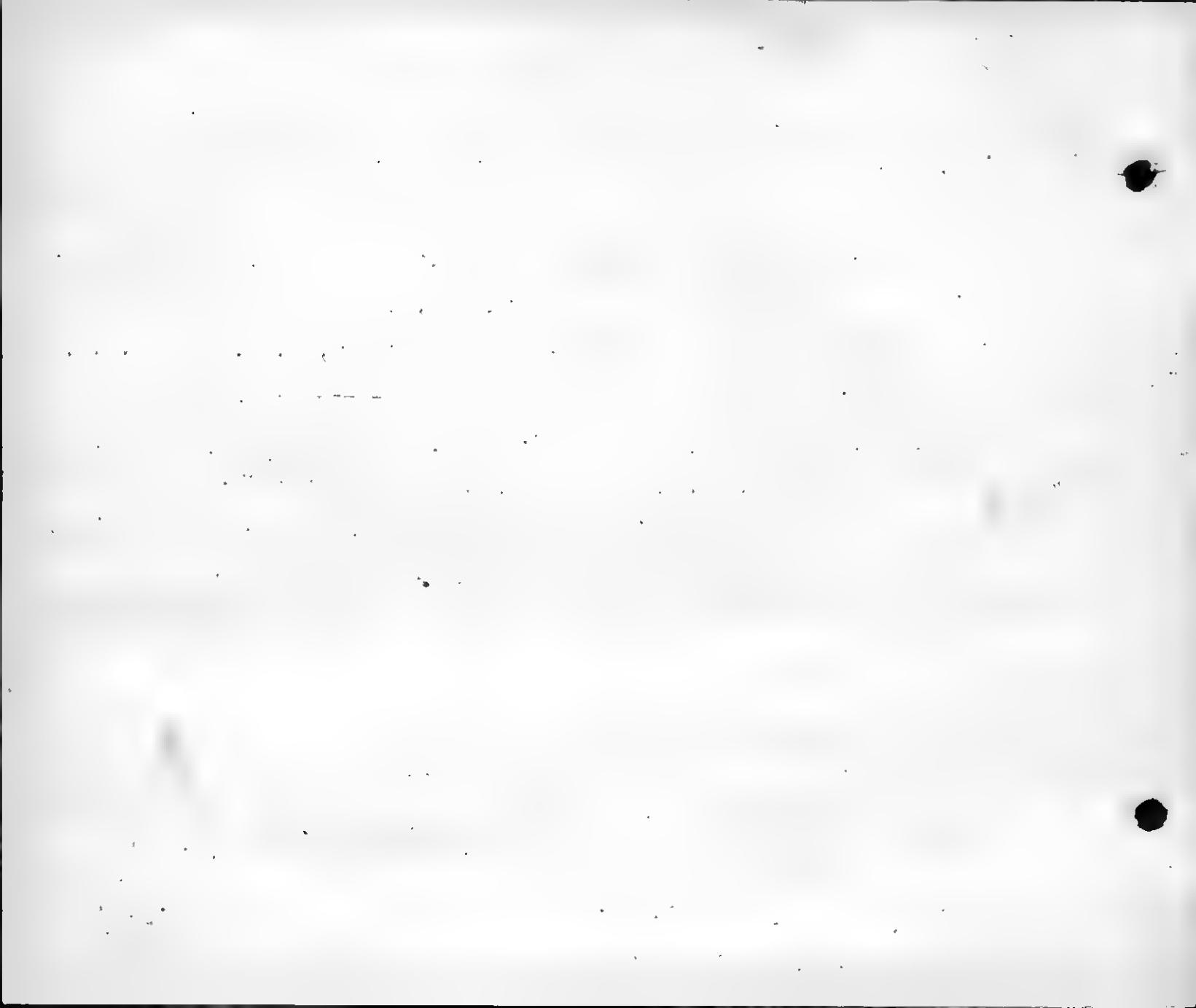
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN lb 8 hrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton | |
| d. STREET ADDRESS 112128 Bluff Hill Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) JOSEPH Edward | | First McCauley | Middle S. |
| 4. DATE OF DEATH 11 4 1959 | | Month 11 | Day 4 |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH 7-27-1886 | | 9. AGE (In years lost birthday) 73 yrs | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Carpenter | 10c. BIRTHPLACE (State or foreign country) Washington D.C. |
| 11. CITIZEN OF WHAT COUNTRY? U.S.A. | | 12. FATHER'S NAME William McCauley | |
| 13. MOTHER'S MAIDEN NAME Anna Badjor | | 14. INFORMANT X. Mary E. Miller | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO Yes | |
| 17. ADDRESS daughter 12128 Bluff Hill Rd. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last Spine & pulmonary, ultima (b) DUE TO ASC II (c) with calcific arter stenosis | |
| | | INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. ADDRESS (Street, city or town, state) 10525 | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) Kensington, Maryland | |
| 21. I certify that I attended the deceased from July 22, 1959 , to 4 Nov. 1959 . That I last saw the deceased alive on 4 Nov. 1959 , and that death occurred at 5:30 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Horace W. Bernton, M.D. | | ADDRESS (Street, city or town, state) 10511 Summit Ave. DATE SIGNED 11-4-59 | |
| PHYSICIAN'S NAME (Type) Horace W. Bernton | | 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | |
| 22b. DATE THEREOF 11-6-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery | |
| 22d. LOCATION (City, town, or county) Rockville, Maryland | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland | | 24a. REC'D BY REGISTRAR DATE NOV 6 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE Clyburn S. Turner | |



HOSPITAL OR CLINIC **PENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please report carbon papers pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | 12770 | | | |
|---|--|---|--|--|--|--|---|-----|---------------|---|--|---|--|
| 12795 CERTIFICATE OF DEATH | | | | | | | | | | Reg. Dist. No. | | | |
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase c. LENGTH OF STAY IN 1b _____ d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 6607 Brookville Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) John | | First | Middle | Last | 4. DATE OF DEATH November 21 1959 | | Month | Day | Year | | | | |
| 5. SEX Kale | | 6. COLOR OR RACE W | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH July 23, 1880 | 9. AGE (In years lost birthday) 79 yrs. IF UNDER 1 YEAR Months Days Hours Min. | | 10a. USA. OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed | | | 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John McDonald | | | | | | | | | | 14. MOTHER'S MAIDEN NAME Ellen McDonald Keohane | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | | 16. SOCIAL SECURITY NO. None | | INFORMANT Julia A. McDonald - 6607 Brookeville | | Address _____ | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | | | | Pulmonary Edema Cerebrovascular accident Ambient Thrombosis | | INTERVAL BETWEEN ONSET AND DEATH 15, Id. One month | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Oct 21, 1959 to Nov 1, 1959 | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) M.D. 8106 Maple Ridge Rd | | 20f. (City or town) Bethesda, Md. (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from Oct 21, 1959 to Nov 1, 1959 , and that I last saw the deceased alive on Nov 14, 1959 , and that death occurred on Nov 21, 1959 , M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Glen, Md. DATE SIGNED Nov 24, 1959 | | | | | | | | | | | | | |
| ACTUAL SIGNATURE M. J. Deegan | | PHYSICIAN'S NAME (Type) St. John's Cemetery | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11-24-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM St. John's Cemetery | | 22d. LOCATION (City, town, or county) Forest Glen, Md. | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph Lawler, Jr. | | ADDRESS 1756 Padua St. N.W. D.C. | | 24a. REC'D BY REGISTRAR Arthur S. Kraus | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | | | | | |



1

TO HOSPITAL OR CLINIC: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

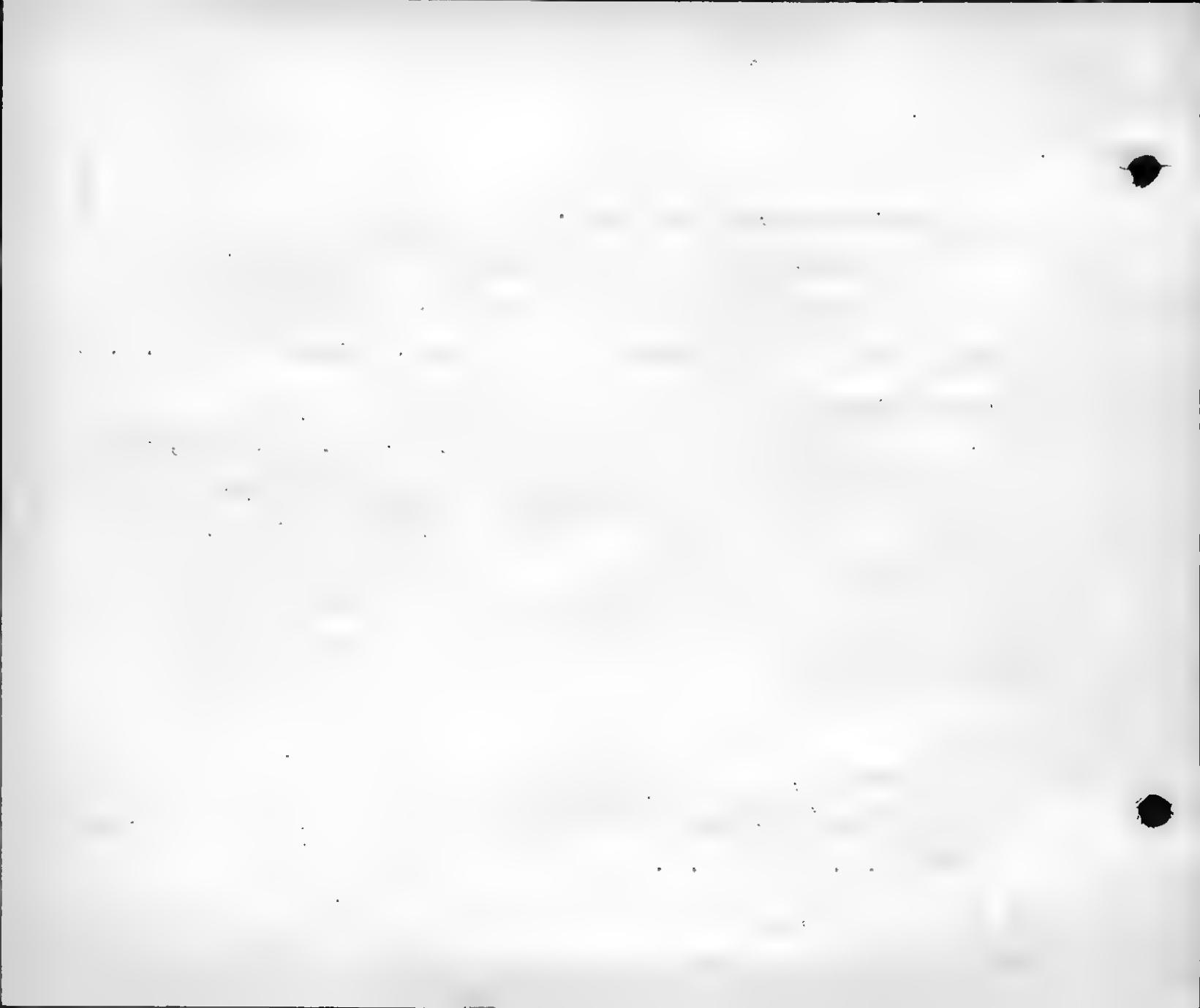
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12796 CERTIFICATE OF DEATH

12771

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|---|--|---------------------------------------|---|---------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland | | b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 92 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Coral Hills | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | e. STREET ADDRESS 1506 52nd Avenue | | f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First Charmaine | Middle Collen | Last McFadden | 4. DATE OF DEATH November 14, 1959 | Month November | Day 14 | Year 1959 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 15, 1954 | 9. AGE (In years last birthday) 5 yrs. | IF UNDER 1 YEAR Months 5 | IF UNDER 24 HRS Days Hours | Min 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child (None) | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) District of Columbia | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME James McFadden | | 14. MOTHER'S MAIDEN NAME Dolores Jones | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO (If yes, give war or dates of service) None | | INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DEGENERATIVE CENTRAL NERVOUS SYSTEM DISEASE - TYPE UNDETERMINED INTERVAL BETWEEN ONSET AND DEATH 35x DUE TO 6 mos | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from August 14, 1959 , to November 14, 1959 , that I last saw the deceased alive on November 14, 1959 , and that death occurred at 6:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11-14-59 | | | | | | | |
| ACTUAL SIGNATURE  | | M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/17/59 | | 22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill | | 22d. LOCATION (City, town, or county) Gaithersburg, Md. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Inc. | | ADDRESS Mt. Rainier, Md. | | 24a. REC'D BY REGISTRAR Arthur S. Kline | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | |
| VS A15 (4) 15M 9/58 | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 'Film 252 11-30-59 ams

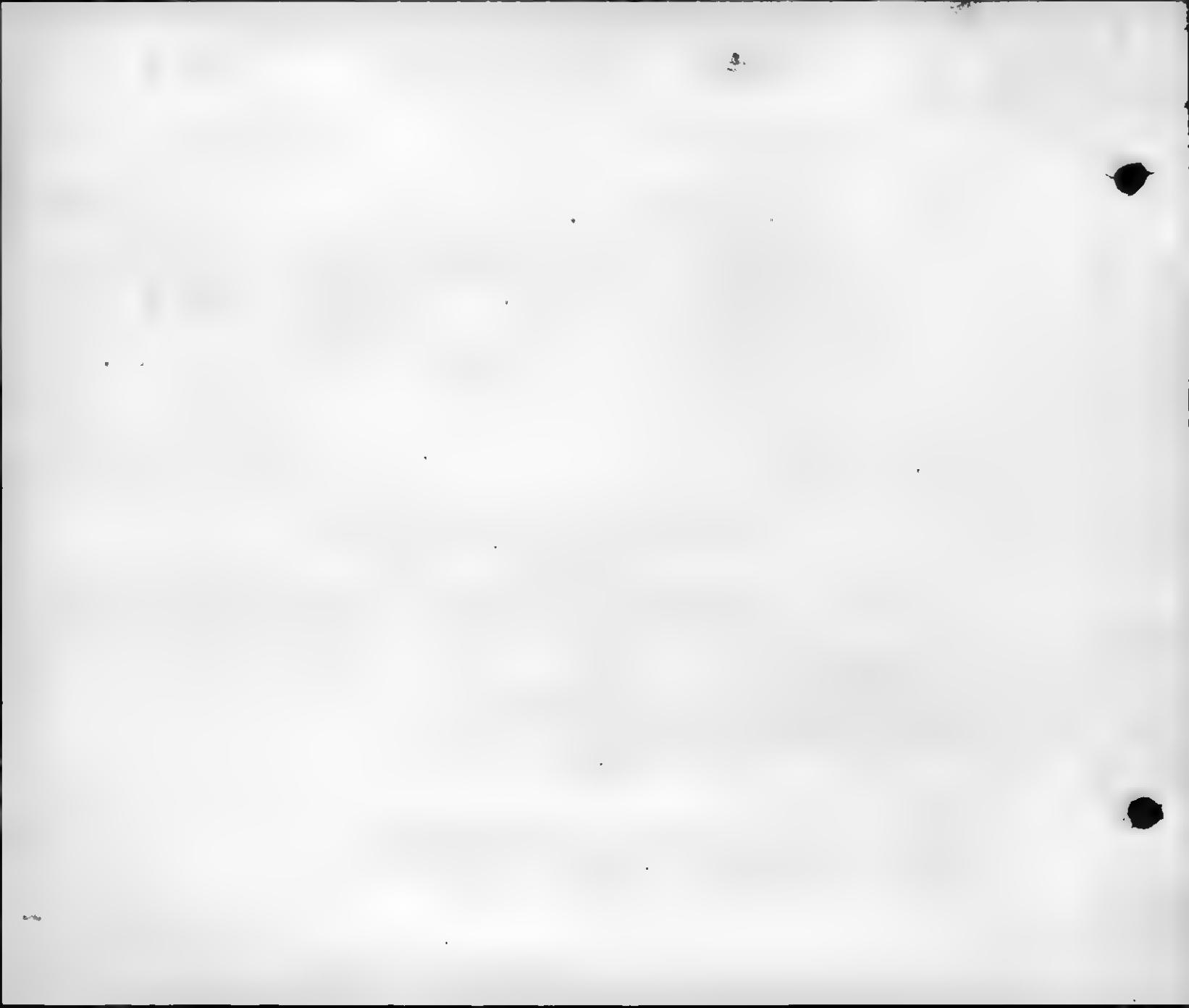
12797

CERTIFICATE OF DEATH

Reg. Dist. No.

12772

| | | | | | | | | |
|---|---------------------------|---|--|--|--|---|-------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland | | b. COUNTY Prince Georges | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 10 ^{1/2} days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Coral Hills | | d. STREET ADDRESS 1506 52nd Avenue | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) Lawton | | First | Middle | Last | 4. DATE OF DEATH McFadden | Month | Day | Year |
| S. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 8, 1956 | 9. AGE (In years last birthday) 3 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Kansas | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | | |
| 13. FATHER'S NAME James McFadden | | | | 14. MOTHER'S MAIDEN NAME Dolores Jones | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO | | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | Spino-cerebellar degeneration | | | | INTERVAL BETWEEN ONSET AND DEATH 3 years | | |
| 753.1 | | DUE TO pyelonephritis, (b) Acute pychonephritisx, renal abscesses | | | | unknown | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (c) | | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) | | (State) |
| 19 | | | | | | | | |
| 21. I certify that I attended the deceased from August 14, 1959, to November 26 1959, that I last saw the deceased alive on November 26, 1959, and that death occurred at 3:35 A.M., from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <i>Winston Abraham</i> M.D. The Clinical Center | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | |
| PHYSICIAN'S NAME (Type) Urishof Abraham M.D. | | | | National Institutes of Health Bethesda 14, Maryland | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/28/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill | | 22d. LOCATION (City, town, or county) Suitland, Md | | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home Inc. | | ADDRESS mt. Rainier, Md. | | 24a. REC'D BY REGISTRAR NOV 30 '59 | | 24b. REGISTRAR'S SIGNATURE <i>Ernest S. Kraus</i> | | |
| | | | | DATE | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

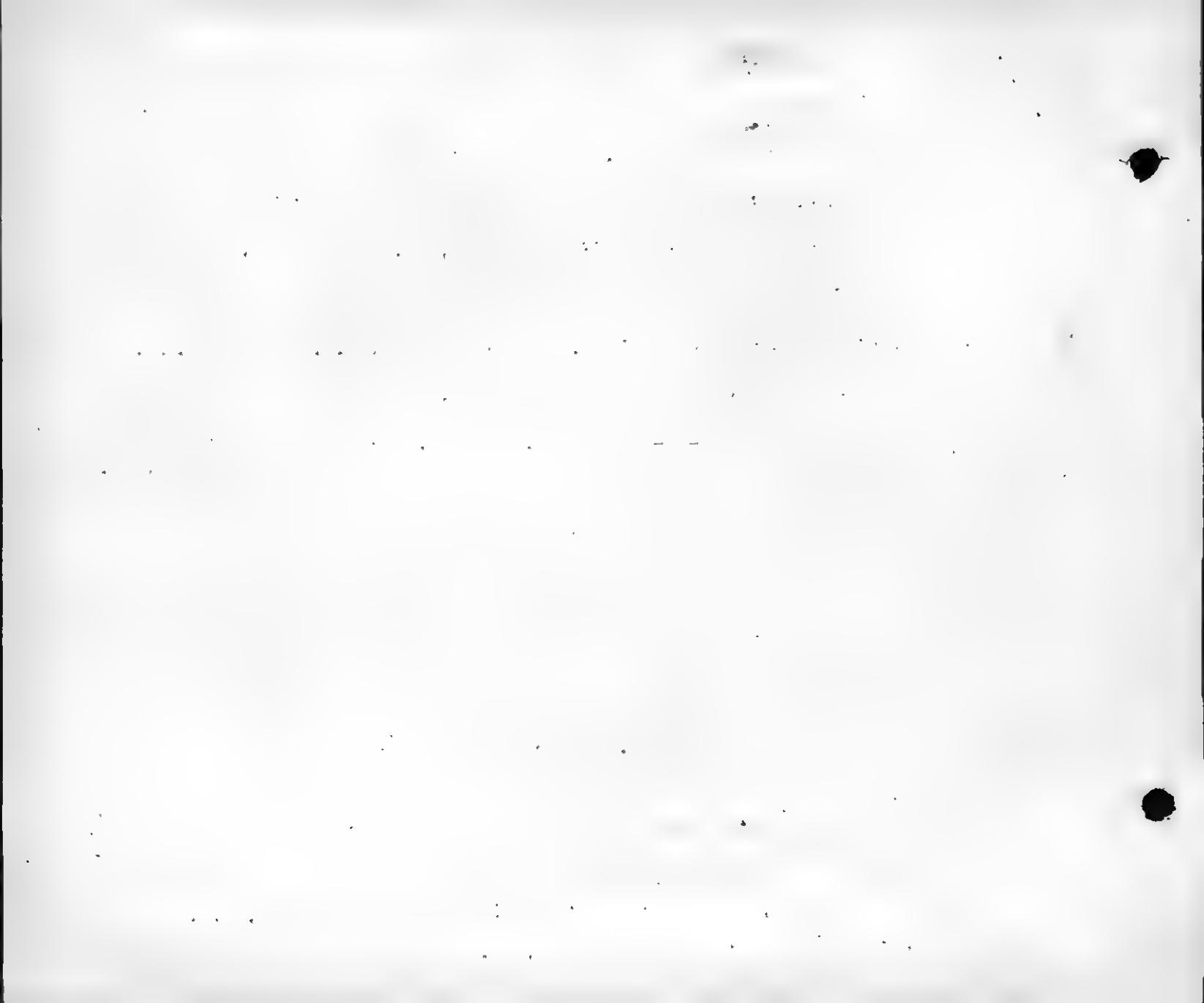
12798

CERTIFICATE OF DEATH

12773

Reg. Dist. No.

| | | | | | | |
|--|--|--|---|--|--|------------------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | 2. USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE MARYLAND | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | c. LENGTH OF STAY IN lb 6 yrs. | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2520 PLYERS MILL ROAD | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | | | |
| 3. NAME OF DECEASED (Type or print) CHARLES | | First FREDERICK | Middle MEYERS, SR. | | | |
| 4. DATE OF DEATH NOV. 18 1959 | | Month NOV. | Day 18 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH 9/7/90 | | 9. AGE (In years last birthday) 69 yrs | 10. IF UNDER 1 YEAR Months 0 | | | |
| 11. BIRTHPLACE (State or foreign country) Washington, D.C. | | 12. IF UNDER 24 HRS. Days 0 | 13. IF UNDER 24 HRS. Hours 0 | | | |
| 14. CITIZEN OF WHAT COUNTRY? U.S.A. | | 15. FATHER'S NAME CHARLES FREDERICK MEYERS | | | | |
| 16. SOCIAL SECURITY NO. 579-09-3182 | | 17. INFORMANT Mrs. Mabel L. Meyers, 2520 Plyers Mill Road | 18. ADDRESS Silver Spring | | | |
| 19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Carcinoma of Liver</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 2 mos | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION LISTED IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 7542 12th St. NW WASH. D.C. | 20f. (City or town) 7542 12th St. NW WASH. D.C. | (County) WASH. D.C. | (State) D.C. |
| 21. I certify that I attended the deceased from Sept 19, 1959 to Nov 18, 1959 , that I last saw the deceased alive on Nov 18, 1959 , and that death occurred at 7:00 P.M. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) WASH. D.C. | | DATE SIGNED 24/10/59 | | |
| ACTUAL SIGNATURE <i>Wm F Greaney</i> | | PHYSICIAN'S NAME (Type) WM F GREANEY M.D. | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 11/21/59 | 22c. NAME OF CEMETERY OR CREMATORIUM PROSPECT HILL CEMETERY | 22d. LOCATION (City, town, or county) WASHINGTON, D.C. | (State) D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Ziska</i> | | ADDRESS SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR NOV 20 '59 | 24b. REGISTRAR'S SIGNATURE <i>Charles S. Turner</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12774

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) | |
| Montgomery MARYLAND | | a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksburg | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksburg | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | First Della | Middle Mae |
| | | Last Miles | 4. DATE OF DEATH Month NOV Day 10 Year 1959 |
| 5. SEX Female White | | 6. COLOR OR RACE WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |
| 8. DATE OF BIRTH April 25, 1882 | | 9. AGE (in years last birthday) 77 yrs | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) None work Kent County, Md., U.S.A. | |
| 13. FATHER'S NAME Kent King | | 14. MOTHER'S MASTERN NAME Emma Brown | |
| 15. WAS DECEASED EVER IN J. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. INFORMANT Address Howard W. Miles, Jr., Gaithersburg, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Arteriosclerosis, generalized | | INTERVAL BETWEEN ONSET AND DEATH 2 yrs ? | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus, mild | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 11/10, 1957, to 11/10, 1957, that I last saw the deceased alive on 11/10, 1959, and that death occurred at 10:25 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) | | DATE SIGNED 11/11/57 | |
| ACTUAL SIGNATURE G. F. Meadows | | M.D. MAIN STREET | |
| PHYSICIAN'S NAME (Type) G. F. Meadows, MD | | DAMASCUS, MD | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11.12.58 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS | | 22d. LOCATION (City, town, or county) (State) Lacalleville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE E. G. Hartman | | 24a. REC'D BY REGISTRAR NOV 13 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE G. Miles & Sons | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

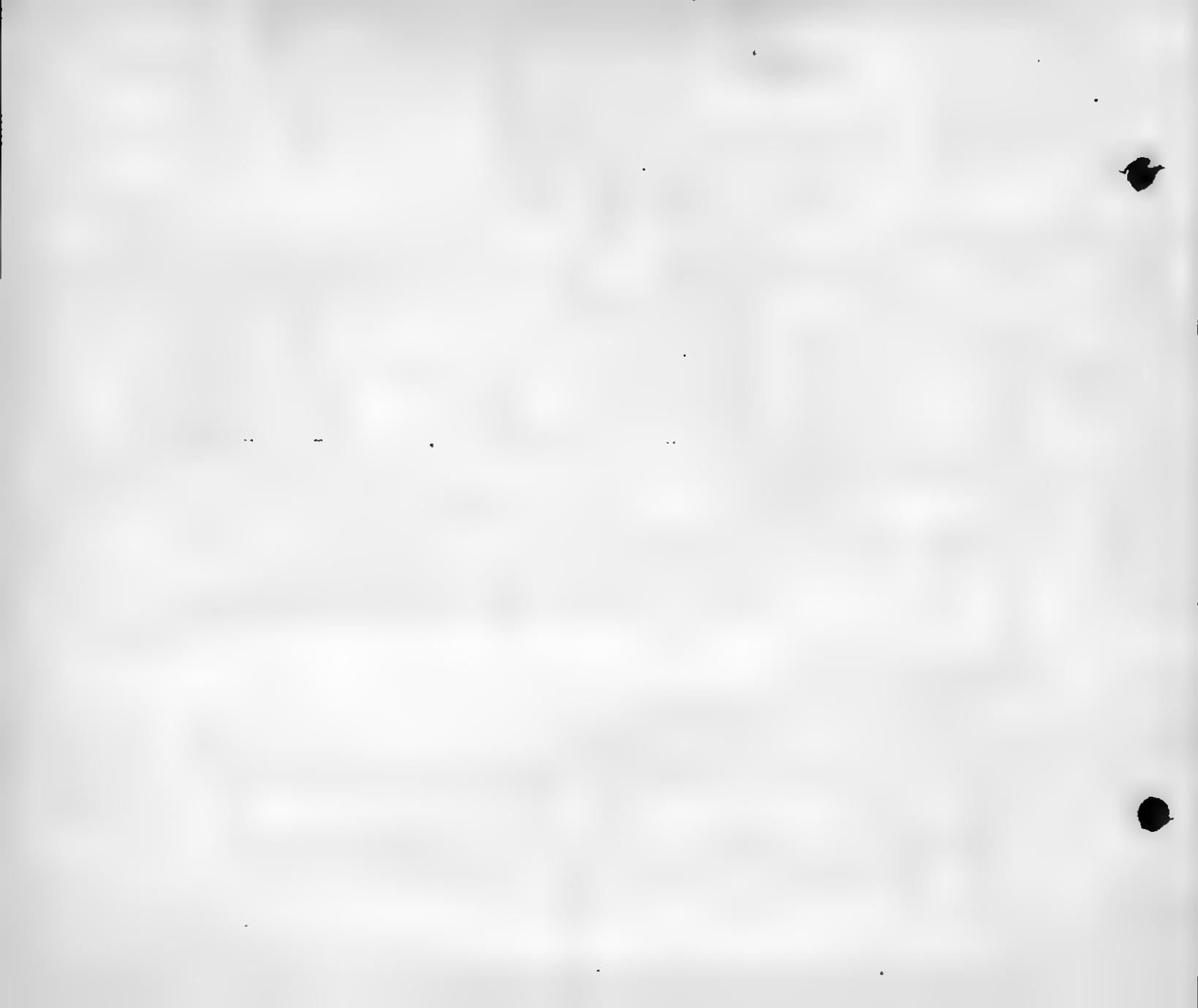
12775

Reg. Dist. No.

12800

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> | | c. LENGTH OF STAY IN 1b <i>15 yrs</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>4948 Battery Lane</i> | | e. STREET ADDRESS <i>14948 Battery Lane</i> | |
| 3. NAME OF DECEASED (Type or print) <i>Fred H. Miller</i> | | First <i>Fred</i> | Middle <i>H.</i> |
| 4. DATE OF DEATH Month <i>Nov</i> | | Month <i>Nov</i> | Day <i>13</i> |
| 5. SEX <i>Male</i> | | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH <i>10-21-83</i> | | 9. AGE (in years last birthday) <i>76 yrs.</i> | 10. IF UNDER 1 YEAR Months <i>0</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>F.C.C.</i> | 11. BIRTHPLACE (State or foreign country) <i>N.Y.</i> |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>W.M. Miller</i> | |
| 14. MOTHER'S MAIDEN NAME <i>Connie Retri</i> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | |
| 16. SOCIAL SECURITY NO. <i>275-01-1065</i> | | 17. INFORMANT Address <i>Neillie T. Miller-wife-same as 2d</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <i>FRANK J Broschart</i> | | DATE SIGNED <i>11-13-59</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Bur-Transit</i> | | 22b. DATE THEREOF <i>11/15/59</i> | |
| 22c. NAME OF CEMETERY OR CREMATORIUM <i>Riverside Cemetery</i> | | 22d. LOCATION (City, town, or county) (State) <i>Coxsackie, New York</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i> | | ADDRESS <i>Bethesda, Maryland</i> | |
| 24a. REC'D BY REGISTRAR DATE <i>NOV 18 '59</i> | | 24b. REGISTRAR'S SIGNATURE <i>Charles E. Russell</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Cancer

12801

CERTIFICATE OF DEATH

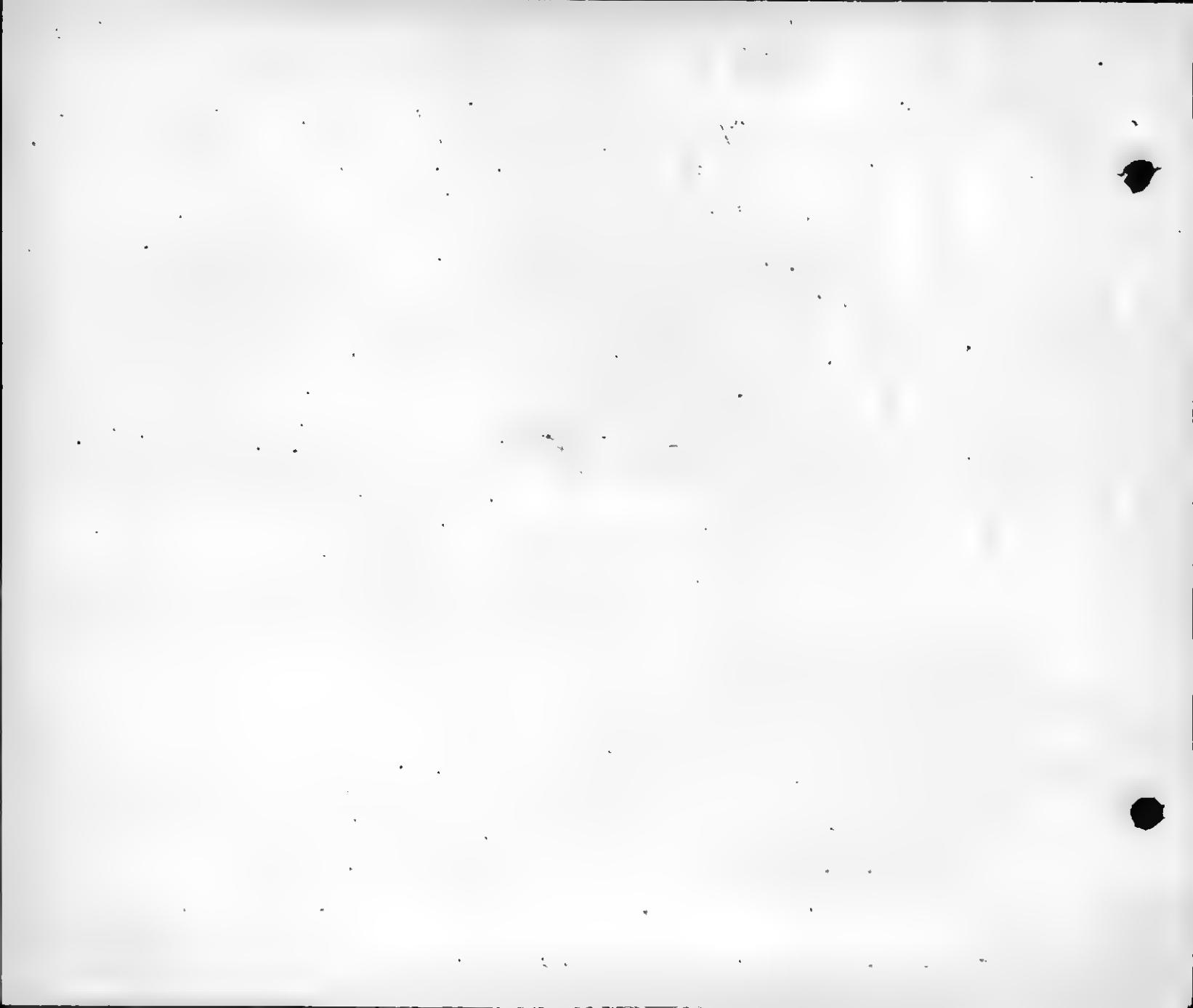
Reg. Dist. No.

12776

| | | | |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>New Jersey</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> | |
| b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <i>Bethesda</i> | | c. LENGTH OF STAY IN 1b <i>2 weeks</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburbans</i> | | e. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] 26 Rockville | |
| 3. NAME OF DECEASED (Type or print) <i>NELLIE W. MILLER</i> | | 4. DATE OF DEATH Month <i>11</i> | Day Year <i>27 1959</i> |
| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>W.</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH <i>May 10, 1915</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i> | 11. BIRTHPLACE (State or foreign country) <i>N. Carolina</i> |
| 13. FATHER'S NAME <i>James Adam Mills</i> | | 14. MOTHER'S MAIDEN NAME <i>Minnie Jane Adams</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>578-01-8746</i> | INFORMANT <i>Husband - Stanley F. Miller</i> |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i> | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cancerous tumor</i> (c) <i>Cancerous tumor</i> | | 2 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>8:25</i> p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>Oct</i> , 1957, to <i>Dec 27, 1959</i> , and that death occurred at <i>10:22 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>W. S. Murphy</i> | | ADDRESS (Street, city or town, state) M.D. <i>Rockville, Maryland</i> DATE SIGNED <i>11/27/59</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>12/1/59</i> | 22c. NAME OF CEMETERY OR CREMATORIUM <i>Parklawn Cemetery</i> |
| 22d. LOCATION (City, town, or county) <i>Rockville, Maryland</i> | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey Bethesda, Maryland</i> | | 24a. REC'D BY REGISTRAR DATE <i>DEC 2 '59</i> | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i> |

TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

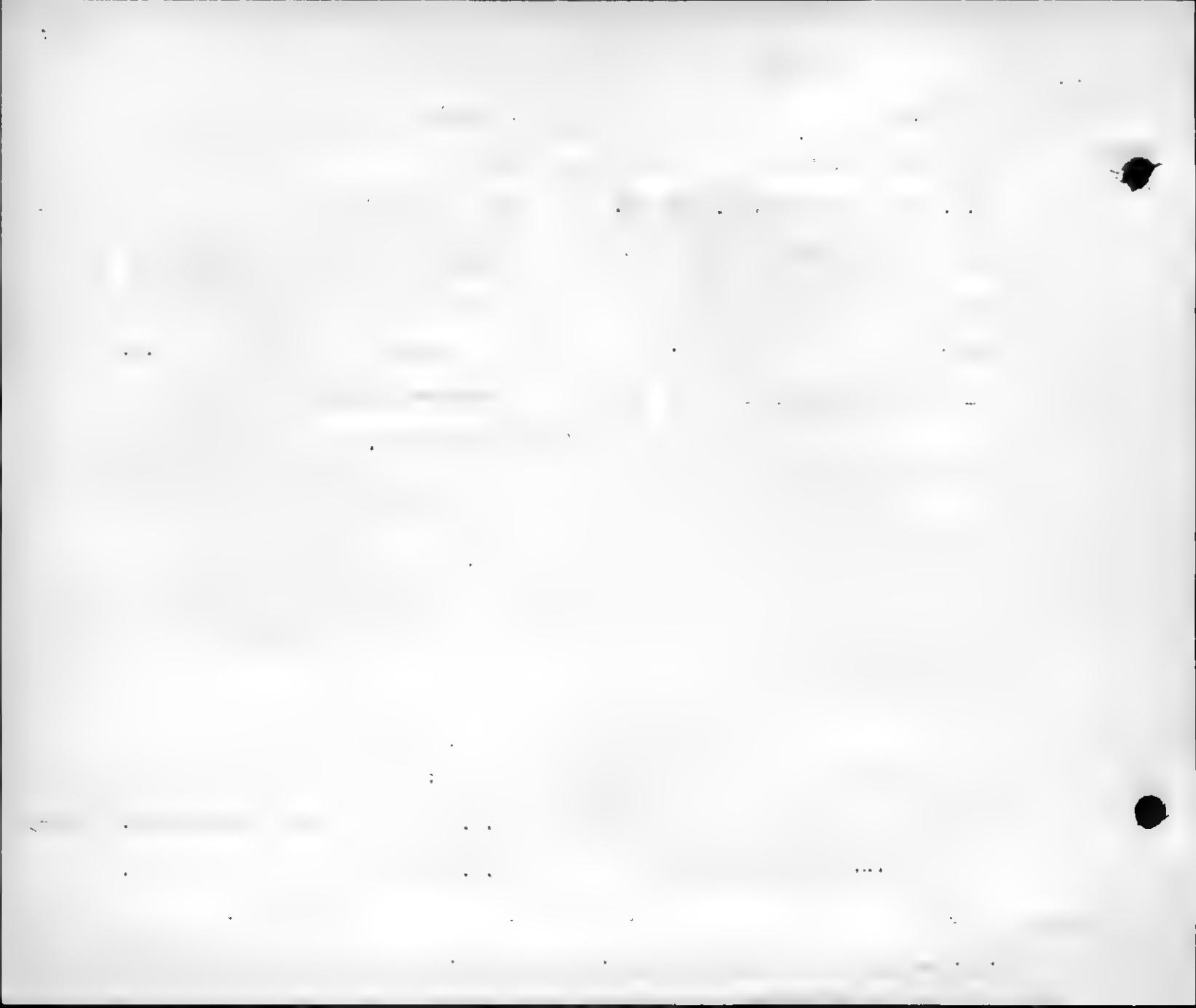
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | | | 12777 | | | |
|---|--|--|--|---|--|--|--|---|--|--|--|---|--|-------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | Reg. Dist. No. 215 | | | |
| 1. PLACE OF DEATH a. COUNTY Montgomery | | | | MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived - If institution Residence before admission) a. STATE Virginia | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN lb 43 days | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk | | | | d. STREET ADDRESS 530 A Chester Street | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md. | | | | | | | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | First William | | Middle Albert | | Last MILLER | | 4. DATE OF DEATH | | Month November | | Day 24 | | Year 19 59 | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 10-30-56 | | 9. AGE (in years last birthday) 3 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | | | | | |
| 10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | | | 11. BIRTHPLACE (State or foreign country) Virginia | | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 13. FATHER'S NAME Albert Raymond Miller | | | | | | 14. MOTHER'S MAIDEN NAME Margaret ALBERT | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None | | INFORMANT (Father) Albert R. Miller | | | | | | Address Same as #2 | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart Disease (Common Ventricle) Post - Operative state DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that I attended the deceased from 12 October, 19 59 , to 24 November, 19 59 that I last saw the deceased alive on 24 November, 19 59 , and that death occurred at 9:15 AM , from the causes and on the date stated above. | | | | | | | | ADDRESS (Street, city or town, state) | | DATE SIGNED | | | | | |
| ACTUAL SIGNATURE <i>Douglas R. Koth</i> | | | | M.D. | | | | U.S. Naval Hospital, Bethesda Md. 11-24-99 | | | | | | | |
| PHYSICIAN'S NAME (Type) D.R. KOTH LCDR MC USN | | | | U.S. Naval Hospital, Bethesda Md. | | | | | | | | | | | |
| 22b. BURIAL CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11-27-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Forest Lawn Park | | | | 22d. LOCATION (City, town, or county) Norfolk, Va. | | | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>R. A. Pumphrey</i> | | | | ADDRESS 7557 Wisconsin Ave. Bethesda Md. | | | | 24a. REC'D BY REGISTRAR NOV 27 '59 | | 24b. REGISTRAR'S SIGNATURE <i>G. Thompson</i> | | | | | |
| VS A15 (4) 15M 9/58 | | | | | | | | | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12778

Reg. Dist. No.

| | | | | | |
|--|--|---|---|---|---------------------------------------|
| 1 PLACE OF DEATH a. COUNTY | | 12803 MONTGOMERY MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | | d. STATE | |
| SILVER SPRING | | 2 MONTHS | | 56 N.Y. MD. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. COUNTY - Montg | |
| 8911 GEORGIA AVENUE | | | | f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| | | | | (RECENTLY MOVED FROM N.Y. CITY) | |
| | | | | g. STREET ADDRESS | |
| | | | | 2911 GEORGIA AVE | |
| h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3 NAME OF DECEASED (Type or print) | | First NETTIE | Middle H. | 4. DATE OF DEATH | Month NOV. |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH | Day 6 Year 1959 |
| FEMALE | | WHITE | | MARCH 23, 1892 | IF UNDER 1 YEAR Months Days Hours Min |
| 67 yrs | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (State or foreign country) | |
| HOUSEWIFE | | | | N.Y. STATE | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12 CITIZEN OF WHAT COUNTRY? | |
| BERNARD COHEN | | CITEL | | U.S. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | INFORMANT Address | |
| | | — | | MR. MARTIN MINTZER 8911 GEORGIA AVE. SILVER SPRING, MD. | |
| 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | BENIGN ADENOCARCINOMA SIGMOID COLON NO MOS | | | |
| 15-33 DUE TO | | WITH LIVER METASTASIS | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. | | (b) — | | | |
| | | DUE TO — | | | |
| | | (c) — | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 19 | | | | | |
| 21. I certify that I attended the deceased from SEPT. 16, 1959 to NOV. 6, 1959 that I last saw the deceased alive on NOV. 6, 1959, and that death occurred at 7:20 A.M. from the causes and on the date stated above | | ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE James A. Roberts | | M.D. 2907 GEORGIA AVE. NOV. 6, 1959 | | | |
| PHYSICIAN'S NAME (Type) | | SILVER SPRING, MD. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF NOV. 8, 1959 | | 22c. NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State) | |
| | | | | New York, N.Y. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE B DANZANSKY & SONS - 3501-14TH ST. N.W. | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE NOV 9 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Cathleen F. Hanrahan | |

ו.ג

ו.ג-בנין גן

ח' ינואר מ-1993 מ-1993 מ-1993 מ-1993 מ-1993 מ-1993

ט' ינואר מ-1993 מ-1993 מ-1993 מ-1993 מ-1993

ט' ינואר מ-1993 מ-1993 מ-1993 מ-1993 מ-1993 מ-1993

ט' ינואר

ט' ינואר מ-1993 מ-1993 מ-1993 מ-1993 מ-1993 מ-1993

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12779

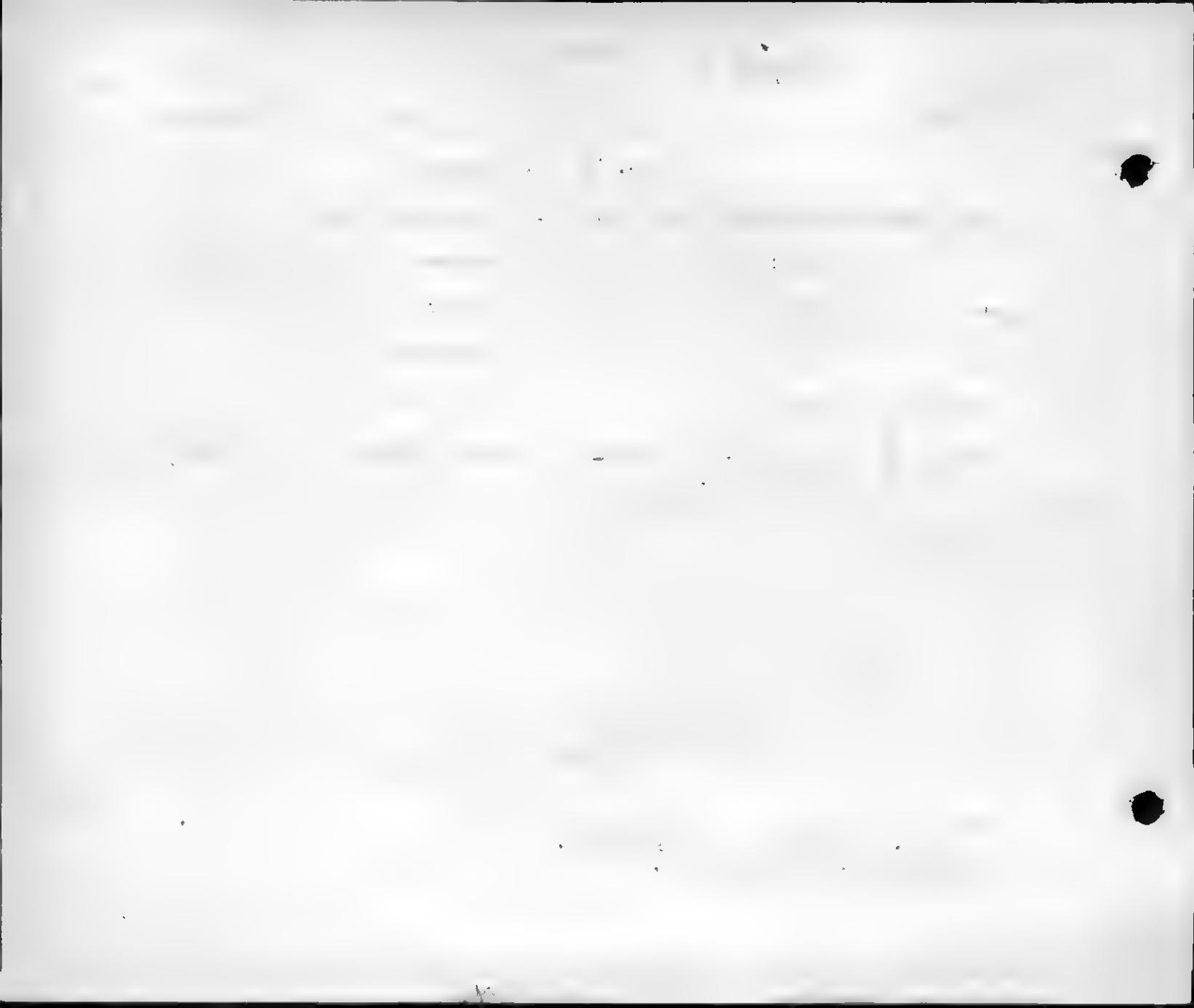
CERTIFICATE OF DEATH

Reg. Dist. No.

12804

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | |
|---|----------------------------------|--|---|--|---------------------------------------|---|---|-------------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | | b. COUNTY MONTGOMERY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY | | c. LENGTH OF STAY IN 1b 10 HRS. 25 MIN. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X DAMASCUS | | d. STREET ADDRESS 25605 RIBGE ROAD | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL, INC. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) | First MICHAEL | Middle BEAL | Last MONTAGUE | 4. DATE OF DEATH NOVEMBER 2 1959 | Month NOVEMBER | Day 2 | Year 1959 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH 11/2/59 | 9. AGE (In years last birthday) yrs. 1 | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. Days 0 | Hours 10 | Min. 25 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME FRANCIS BEAL MONTAGUE | | | 14. MOTHER'S MAIDEN NAME MARY ANNE LAWRENCE | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | INFORMANT HOSPITAL RECORDS | | Address OLNEY, MARYLAND | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776 X DUE TO (Birth weight 1 lb 12 oz) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I attended the deceased from NOVEMBER 2, 1959 , to NOVEMBER 2, 1959 at I last saw the deceased alive on NOVEMBER 2, 1959 , and that death occurred at 6:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Druid Theatre Building, 11/3/59 | | | | | | | | |
| ACTUAL SIGNATURE M. McKendree Boyer, M.D. PHYSICIAN'S NAME (Type) M. M. BOYER, M. D. | | | | | | | | |
| 22a. BURIAL/CREMATION REMOVAL (Specify) 11-4-59 | | 22b. DATE THEREOF 11-4-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM DAMASCUS, MARYLAND | | 22d. LOCATION (City, town, or county) Richmond, Va. (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Thomas J. Harlow 3531 Georgia Ave NW | | | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE NOV 9 '59 | 24b. REGISTRAR'S SIGNATURE Arthur S. Krause | |

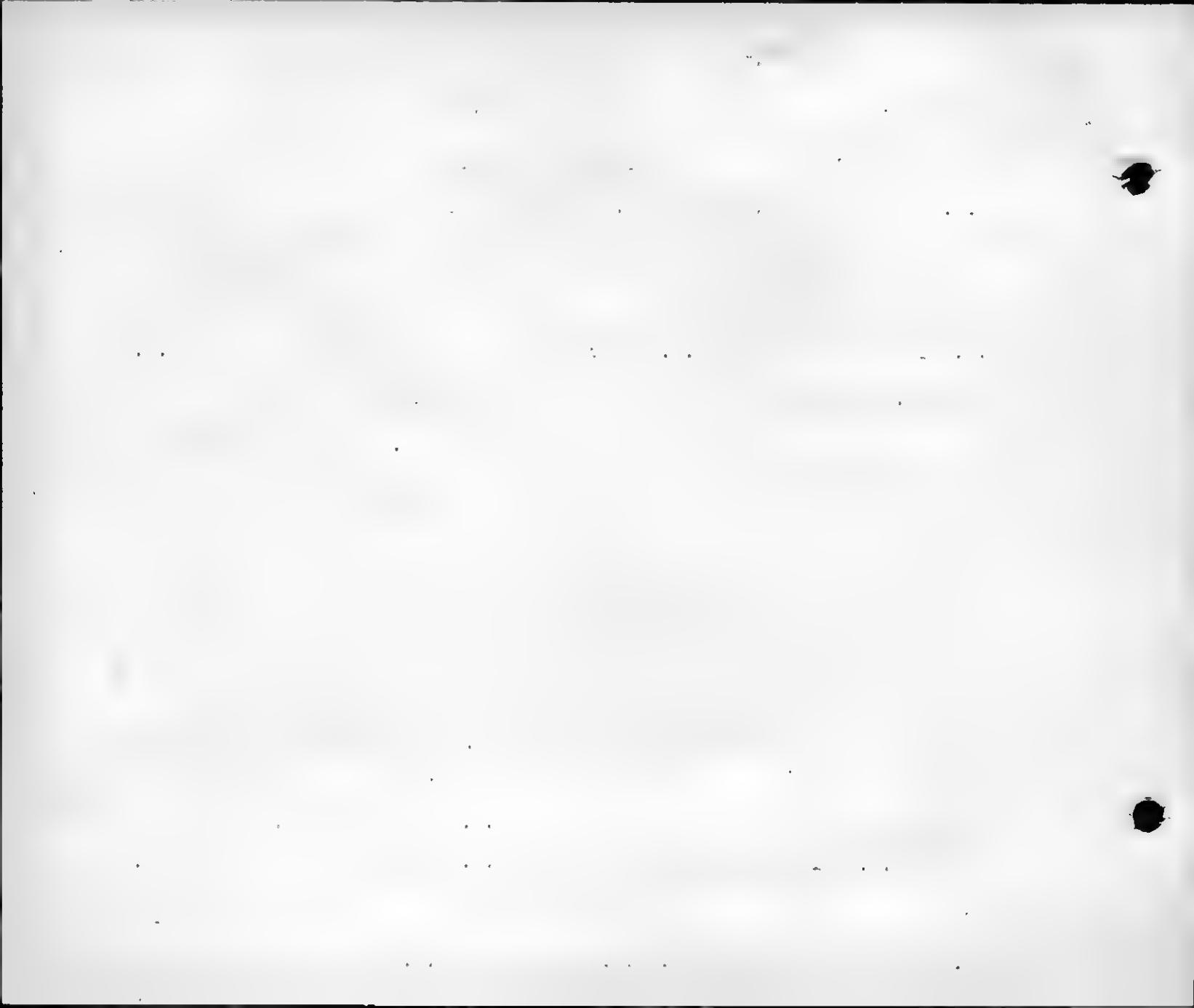


1

TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | 12780 | | | | |
|--|--|--|--|---|---|---|--|--|--|--|----------------|---|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | Reg. Dist. No. 215 | | | | |
| 1. PLACE OF DEATH a. COUNTY Montgomery | | | | | MARYLAND Flordia | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | | c. LENGTH OF STAY IN lb 10 days | | | | | a. STATE Rural | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md. | | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maitland | | | | | b. COUNTY 408 | | | | |
| 3. NAME OF DECEASED (Type or print) Thomas | | | | | First Middle Last James MORGAN | | | | | 4. DATE OF DEATH November 10 1959 | | Month Day Year Month Day Year | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7-7-37 | | 9. AGE (In years last birthday) 22 yrs. | | F. UNDER 1 YEAR Months Days Hours Min | | IF UNDER 24 HRS | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy | | | | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Government | | | | | 11. BIRTHPLACE (State or foreign country) Wisconsin | | | | |
| 13. FATHER'S NAME Harold S. Morgan | | | | | 14. MOTHER'S MAIDEN NAME Nell WHITTY | | | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or date of service) Yes | | | | | 16. SOCIAL SECURITY NO. 395 32 5159 | | | | | INFORMANT (Wife) Sally J. Morgan | | Address Same as #2 | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 292.4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b): DUE TO (c): DUE TO | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 34 days | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 20a. ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, of item 18) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | | |
| 21. I certify that I attended the deceased from 31 October , 1959 , to 10 November , 1959 that I last saw the deceased alive on 10 November , 1959 and that death occurred at 8:05A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Joseph E. Stotcher</i> M.D. U.S. Naval Hospital, Bethesda Md. 11-10-59 | | | | | | | | | | | | | | |
| PHYSICIAN'S NAME (Type) J.E. STITCHER LT MC USN | | | | | U.S. Naval Hospital, Bethesda Md. | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11-13-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Glenhaven Cemetery | | | | | 22d. LOCATION (City, town, or county) Winter Park Florida | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers</i> W.W. Chambers | | | | | ADDRESS 1400 Chapin St. N.W. Washington, | | | | | 24a. REC'D BY REGISTRAR Dec 6 NOV 16 '59 | | 24b. REGISTRAR'S SIGNATURE <i>John S. Trahan</i> | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12685

CERTIFICATE OF DEATH

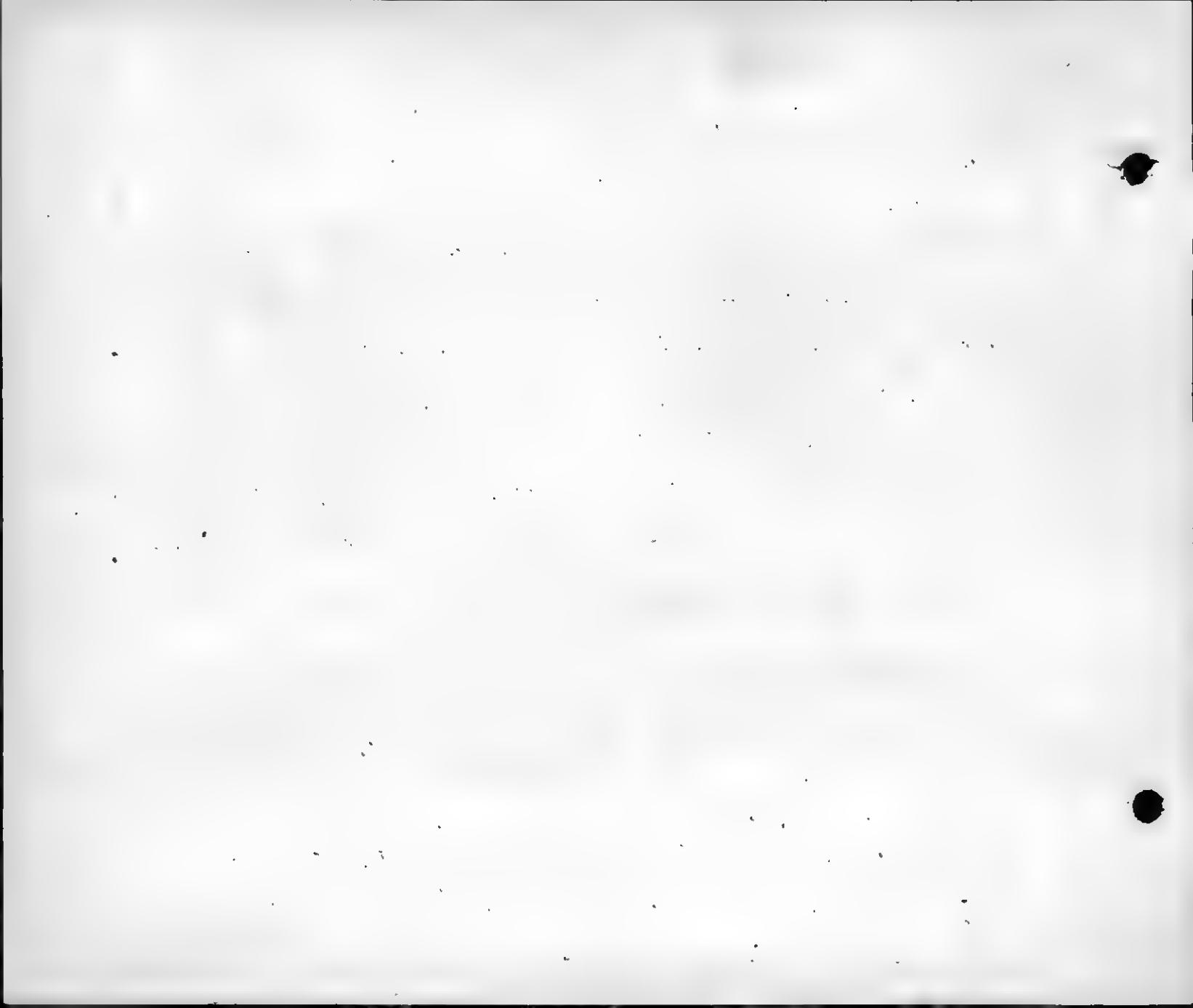
Reg. Dist. No.

12781

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK | | c. LENGTH OF STAY IN 1b 2 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SANITARIUM & HOSP. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED First THOMAS Middle JAMES Last MURRAY | | 4. DATE OF DEATH Month NOV Day 7 Year 1959 | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH 2-21-93 | |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. AGE (In years lost birthday) 66 yrs. | |
| 10c. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLEK-PST DEPT.N.Y | | 10b. KIND OF BUSINESS OR INDUSTRY 4560vt | |
| 11. BIRTHPLACE (State or foreign country) New Jersey | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John MURRAY | | 14. MOTHER'S MAIDEN NAME ROSE COWAN. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? YES | | 16. SOCIAL SECURITY NO W.W.I ARMY Unknwown | |
| 17. INFORMANT HOSP. RECORDS | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 3 days Acute Myocardial Infarction Chronic Coronary Vascular Disease | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 11-4, 1959, to 11-7, 1959, that I last saw the deceased alive on 11-7, 1959, and that death occurred at 10:30 A.M., from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) DATE SIGNED Haldor Fleischman MD 1432 QUEENS CHAPEL RD Ronald S. FLEISCHER Hyattsville Md 11-7-59 | |
| ACTUAL SIGNATURE | | PHYSICIAN'S NAME (Type) Ronald S. FLEISCHER Hyattsville Md | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF Nov. 11, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery | | 22d. LOCATION (City, town, or county) Washington D.C. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Chambers Co Inc Riverdale Md | | 24a. REC'D BY REGISTRAR DATE NOV 10 '59 | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

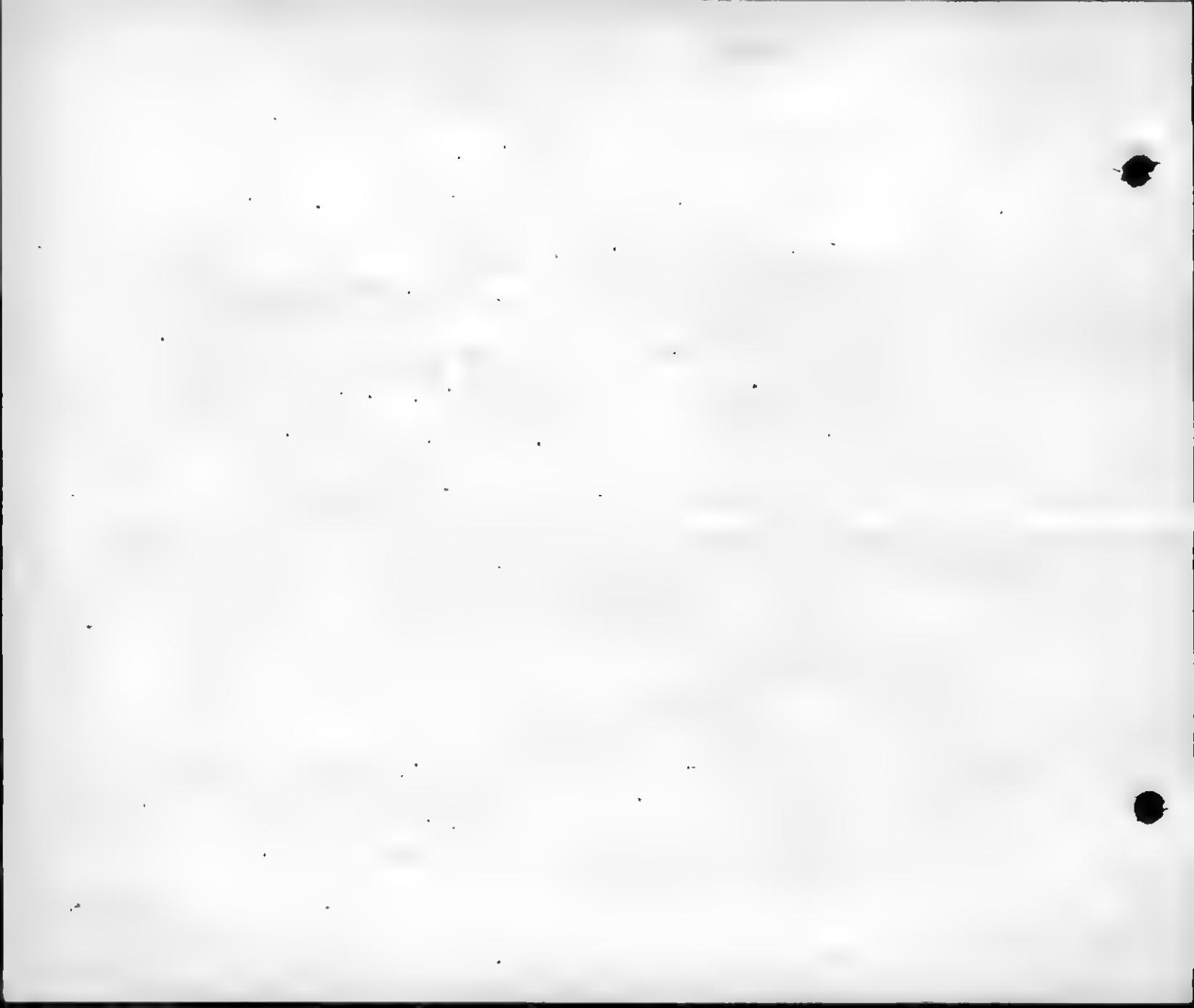
12686

CERTIFICATE OF DEATH

Reg. Dist. No.

12782

| | | | | | | | |
|--|----------------------------------|---|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> | | b. COUNTY <i>Prince George</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park 12</i> | | c. LENGTH OF STAY IN lb <i>3 hrs.</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bladensburg</i> | | d. STREET ADDRESS <i>5108 Quincy St.</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San. + Hosp.</i> | | | | e. DATE OF DEATH Month <i>11</i> — Day <i>10</i> Year <i>1959</i> | | f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First <i>Emmett</i> | Middle <i>Hiram</i> | Last <i>Nanna</i> | 4. DATE OF DEATH Month <i>11</i> — Day <i>10</i> Year <i>1959</i> | | | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>10-23-87</i> | | 9. AGE (In years last birthday) <i>72 yrs.</i> | IF UNDER 1 YEAR Months <i>92</i> Days <i>0</i> Hours <i>0</i> Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Fed. Employee</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Ohio</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | |
| 13. FATHER'S NAME <i>Vinton A. Nanna</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Addie Sheldon</i> | | Address | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>yes</i> <i>WWI</i> | | 16. SOCIAL SECURITY NO. | | INFORMANT <i>Pt's Hosp. Record</i> | | | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive posterior Coronary Infarction</i> INTERVAL BETWEEN ONSET AND DEATH <i>One day</i> | | | | | | | |
| DUE TO <i>420.1</i> | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. <i>7006 New Hampshire Ave Takoma Park MD</i> | | (County) (State) | |
| 21. I certify that I attended the deceased from <i>Nov 10, 1956</i> to <i>Nov 10, 1959</i> , that I last saw the deceased alive on <i>Nov 10, 1959</i> , and that death occurred at <i>9:25P M</i> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Ernest A. Sarao</i> ADDRESS (Street, city or town, state) <i>7006 New Hampshire Ave Takoma Park MD</i> DATE SIGNED <i>11/10/59</i> | | | | | | | |
| PHYSICIAN'S NAME (Type) | | Ernest A. Sarao | | Tokoma Park, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>Nov 14, 1959</i> | | 22c. NAME OF CEMETERY OR CREMATORIAL <i>Greenlawn Memorial</i> | | 22d. LOCATION (City, town, or county) <i>Moundsville West Virginia</i> (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i> | | ADDRESS <i>Hyattsville, Md.</i> | | 24a. REC'D BY REGISTRAR DATE <i>NOV 18 '59</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12783

12806

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN TB

3 weeks

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Congressional Manor Sanitarium

3. NAME OF DECEASED
(Type or print)First
LouiseMiddle
D.Last
Neff.

4. DATE OF DEATH

Month
11Day
1Year
1959

5. SEX

Female white

6. COLOR OR RACE

7 MARRIED NEVER MARRIED
WIDOWED DIVORCED

8. DATE OF BIRTH

6/6/1880

9. AGE (In years last birthday)

79 yrs

10. LSJAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Home maker

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Indiana

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frank De Forest

14. MOTHER'S MAIDEN NAME

Mary Beers

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

none

INFORMANT

Sanitarium Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Heart Failure
Arteriosclerotic Heart Disease 8 yearsINTERVAL BETWEEN
ONSET AND DEATH

6 hours

MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 1920d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Jan 1958, to death, 19, that I last saw the deceased alive on Nov 1, 1959, and that death occurred at 11 P.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE

Marcelle Forest M.D. 1746 K St N.W. 11/15/59

PHYSICIAN'S NAME (Type)

MARCELLE FOREST

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial 11-5-1959

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Joseph Shuster, Doss, 1756 Park Rd. N.W. D.C.

ADDRESS

24a. REC'D BY REGISTRAR

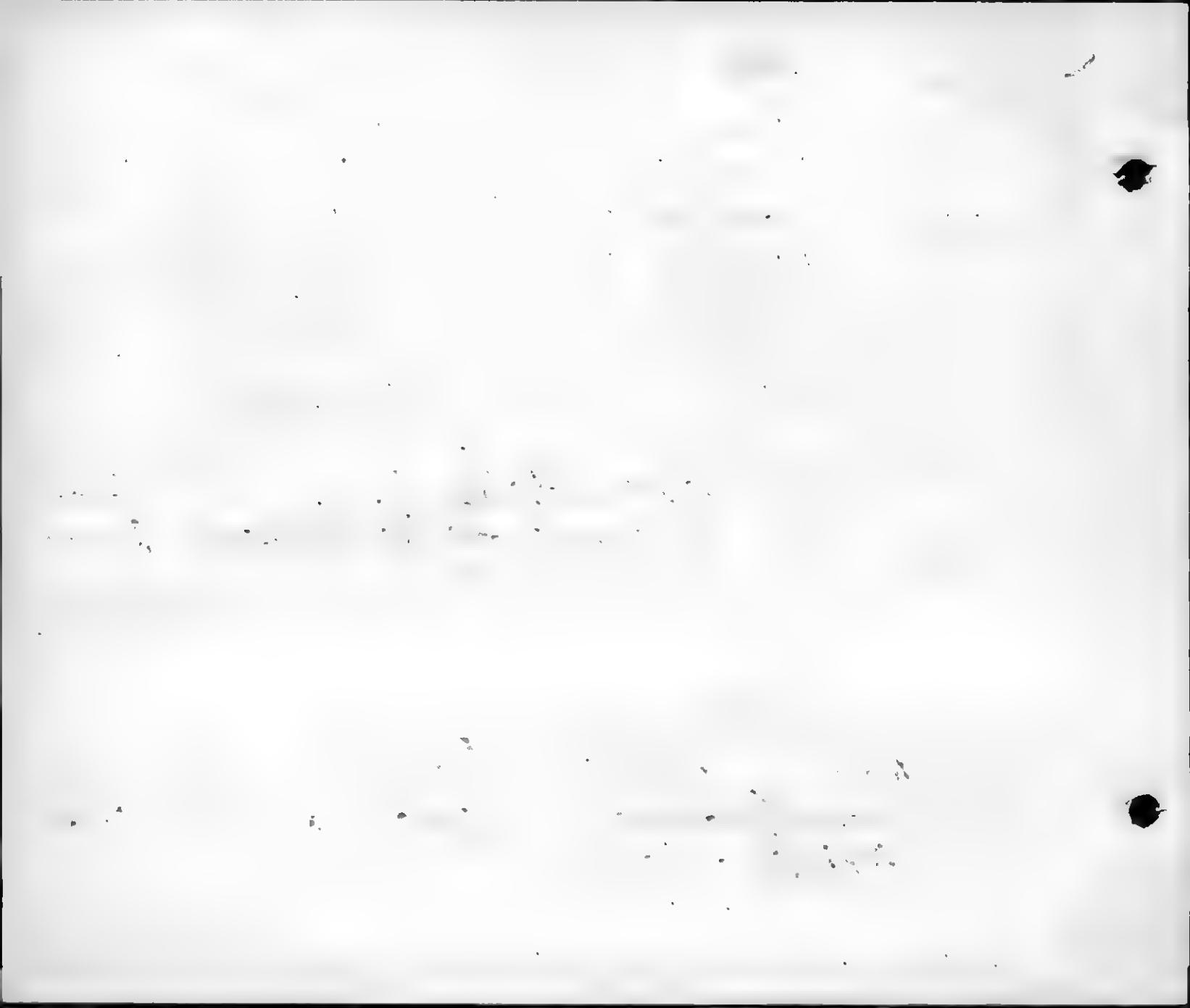
DATE NOV 4 '59

24b. REGISTRAR'S SIGNATURE

Curtis G. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR
may be retained
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

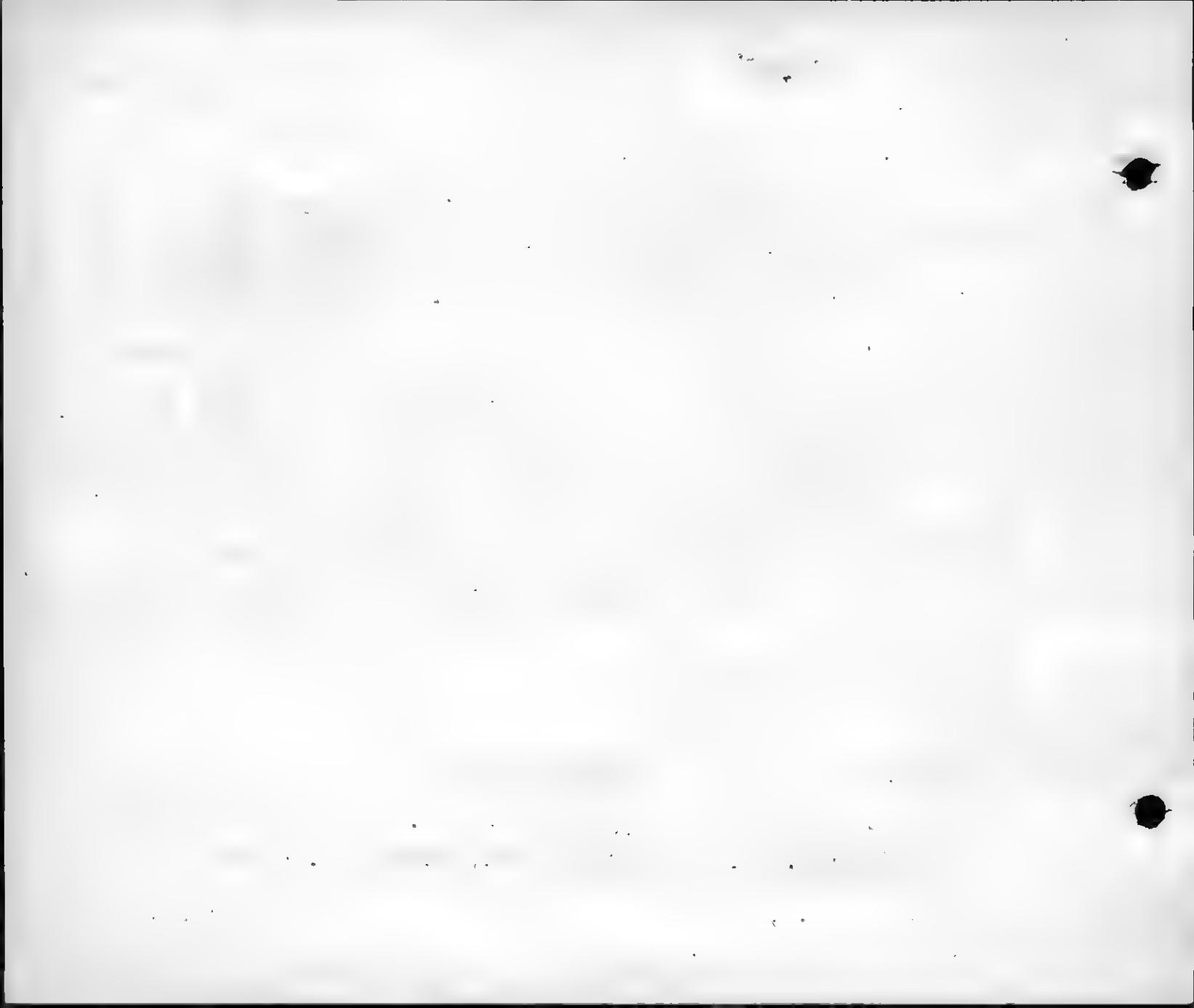
Item 8 Film G251 11/12/51 1wk

12784

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN lb 1 Month | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital | | e. STREET ADDRESS 3732 Manor Road | |
| 3. NAME OF DECEASED (Type or print) Margaret Agnes O'Reilly | | 4. DATE OF DEATH November 4 1959 | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1889 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 70 yrs |
| 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Kirby | | 14. MOTHER'S MAIDEN NAME Margaret Ford | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | INFORMANT Stephen O'Reilly |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Terrestrial Bronchopneumonia | | | |
| (c) DUE TO Carcinoma Endometrial | | | |
| Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Sept 8 1959 to Nov 4 1959 that I last saw the deceased alive on Nov 4 1959 , and that death occurred at 12:35 AM , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) M.D. 5409 Del Ray Ave., Bethesda, Md. DATE SIGNED Robert G. Angle 11/4/59 | |
| ACTUAL SIGNATURE Robert G. Angle | | PHYSICIAN'S NAME (Type) Robert G. Angle 5009 Del Ray Ave., Bethesda, Md. 11/4/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Nov. 7, 1959 | 22c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland | | 22d. LOCATION (City, town, or county) Silver Spring, Maryland | |
| ADDRESS Robert A. Pumphrey, Bethesda, Maryland | | 24a. REC'D BY REGISTRAR DATE NOV 6 '59 | 24b. REGISTRAR'S SIGNATURE Arthur S. Evans |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

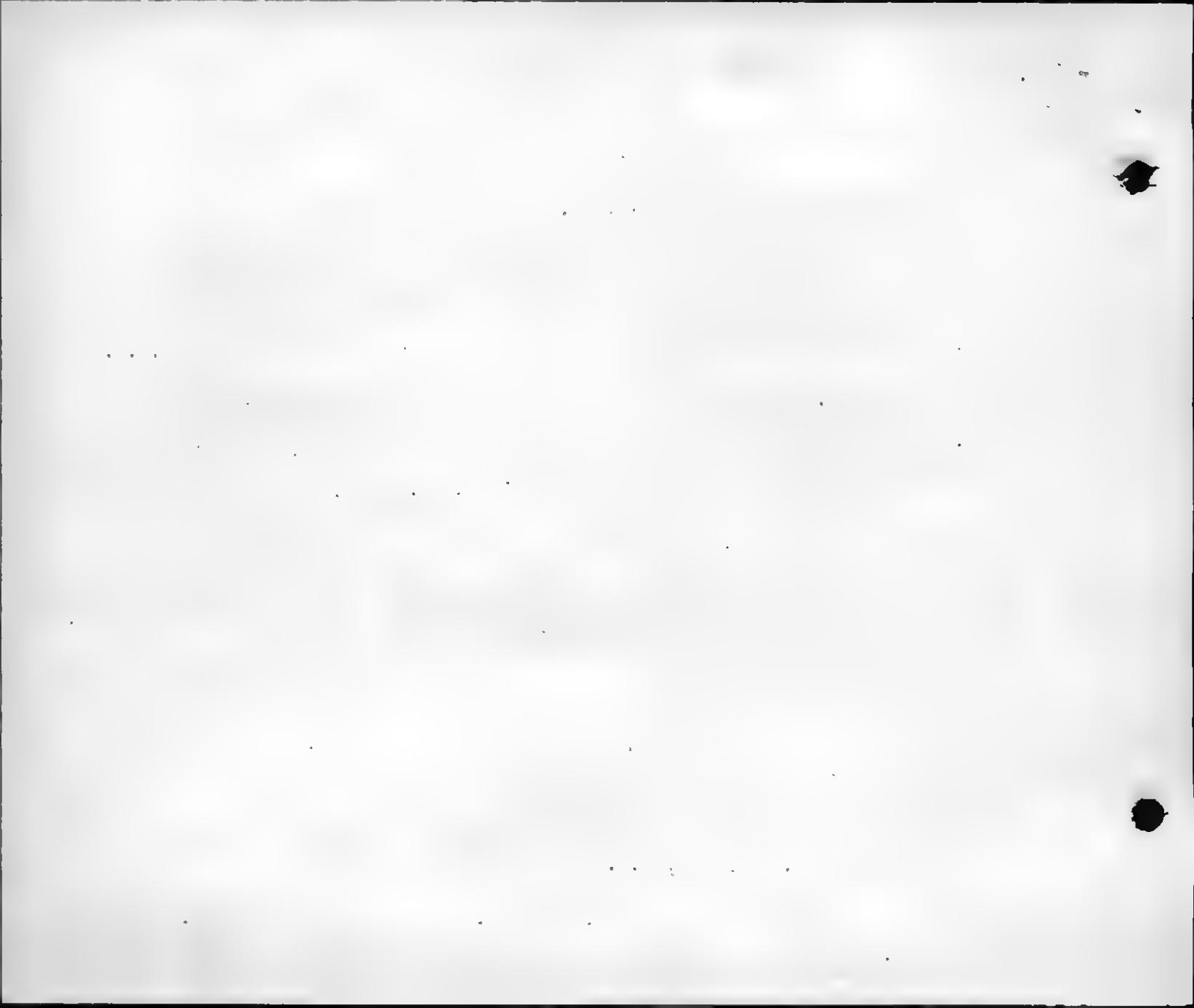
12808

CERTIFICATE OF DEATH

Reg. Dist. No.

12785

| | | | | | | | | | | | |
|---|----------------------------------|--|---|---|---------------------------------------|---|-------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE North Carolina | | b. COUNTY | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 56 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilmington | | d. STREET ADDRESS 2317 Moss Street | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) | First Curley | Middle Neal | Last Packer | 4. DATE OF DEATH November 18 1959 | Month November | Day 18 | Year 1959 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH September 22, 1898 | 9. AGE (In years last birthday) 61 yrs. | IF UNDER 1 YEAR Months 6 | IF UNDER 24 HRS Hours 12 | IF UNDER 24 MRS Days 0 | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Street Maintenance | | 10b. KIND OF BUSINESS OR INDUSTRY Private | | 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME Charlie W. Packer | | | | 14. MOTHER'S MAIDEN NAME Florence Willoughby | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO Unascertainable | | INFORMANT The Medical Record | | Address The Clinical Center, Bethesda 14, Maryland | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocardial Infarction. INTERVAL BETWEEN ONSET AND DEATH days 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) Coronary Artery Disease ? DUE TO (c) | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 20d. INJURY OCCURRED p. m. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 19 | | | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 9-23-59 , 19 59 , to 11-18-59 , 19 59 , that I last saw the deceased alive on 11-18-59 , 19 59 , and that death occurred at 1:00 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Vincent T. Andriole M.D. ADDRESS (Street, city or town, state) 11/19/59 PHYSICIAN'S NAME (Type) Vincent T. Andriole, M.D. DATE SIGNED | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit | | 22b. DATE THEREOF 11/19/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Mem. Park | | 22d. LOCATION (City, town, or county) Wilmington, N. Carolina | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Maryland | | 24a. REC'D BY REGISTRAR DATE NOV 23 '59 | | 24b. REGISTRAR'S SIGNATURE Cathleen S. Krause | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

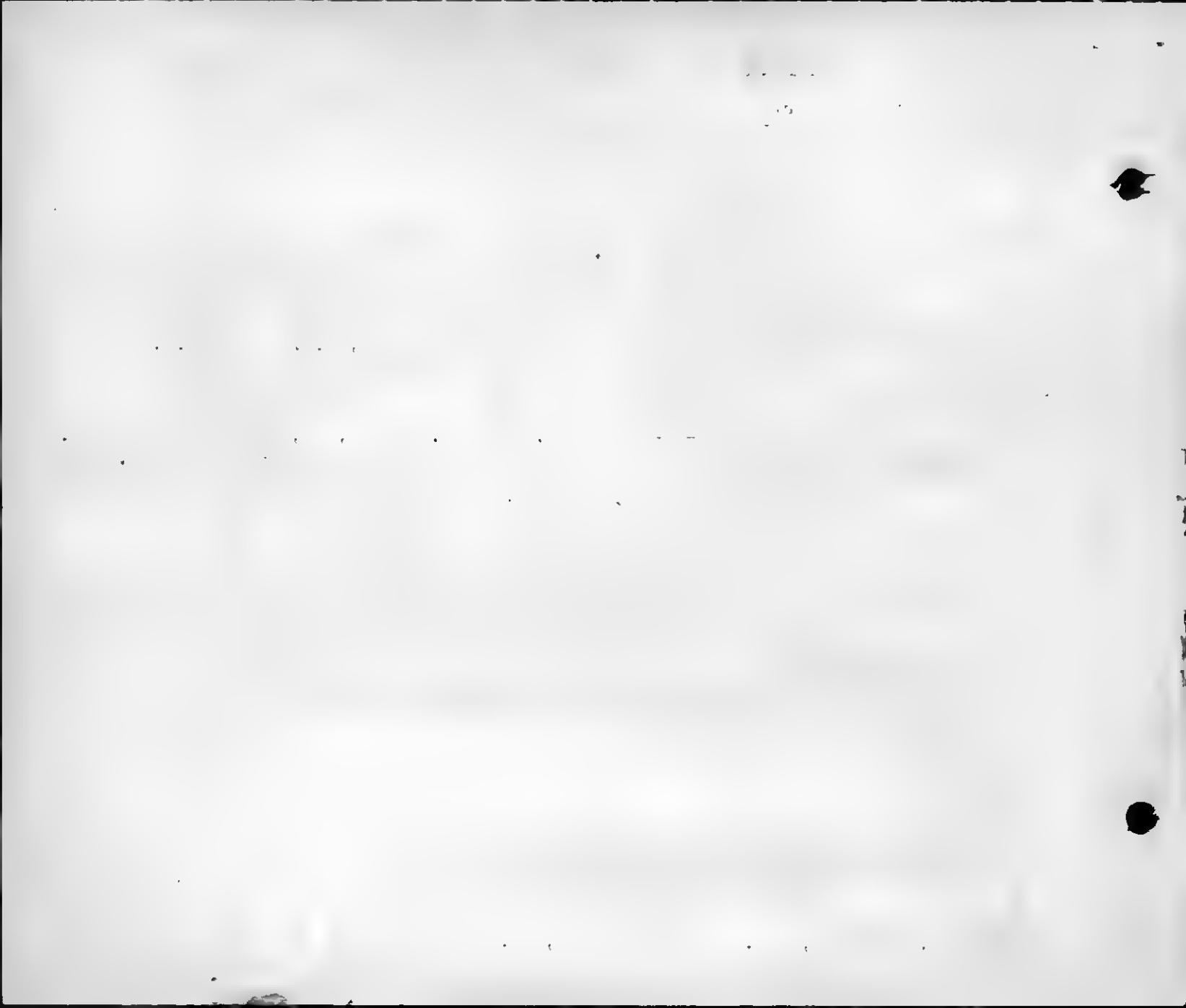
12786

12809

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | |
|--|--|--|---|---|--|---|----------------------------------|----------------------------|-------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> | | b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. LENGTH OF STAY IN lb <u>6 years</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md.</u> | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11707 College View Dr.</u> | | d. STREET ADDRESS <u>11707 College View Dr.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Vincent</u> | | First <u>J.</u> | Middle <u>Papace</u> | Last | 4. DATE OF DEATH <u>November 1 1959</u> | Month | Day | Year | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH <u>8/27/14</u> | 9. AGE (In years last birthday) <u>45</u> | IF UNDER 1 YEAR Months <u>4</u> | IF UNDER 24 HRS Days <u>1</u> | Hours <u>00</u> | Min. <u>00</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cartographer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Army Map Service</u> | | 11. BIRTHPLACE (State or foreign country) <u>New York City, N.Y.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>JOHN PAPACE</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>VINCENZA BASILE</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> | | 16. SOCIAL SECURITY NO. <u>WW #2</u> | | 17. INFORMANT <u>Mrs. Edith E. Papace, 11,707 College View Dr.</u> | | Address <u>Silver Spring Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema . Cerebral Anoxia</u> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>myocardial Infarction</u> DUE TO (c) | | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) <u>M.D.</u> | | (County) <u>MONTGOMERY</u> | (State) <u>MARYLAND</u> |
| 21. I certify that I attended the deceased from <u>March 12, 1959</u> , to <u>Oct 29, 1959</u> , that I last saw the deceased alive on <u>Oct 29, 1959</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above. | | | | | | | | | |
| ADDRESS (Street, city or town, state) <u>M.D. 10110 Georgia Ave. Silver Spring, Md.</u> | | | | | | | | | |
| DATE SIGNED <u>Nov 6, 1959</u> | | | | | | | | | |
| ACTUAL SIGNATURE <u>Edward J. Richards</u> | | PHYSICIAN'S NAME (Type) <u>Edward J. Richards</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>11/4/59</u> | | 22c. NAME OF CEMETERY OR CREMATORIAL GATE OF HEAVEN CEMETERY | | 22d. LOCATION (City, town, or county) <u>MONTGOMERY COUNTY, MARYLAND</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. POMPHREY, INC.</u> | | ADDRESS <u>SILVER SPRING, MD.</u> | | 24a. REC'D BY REGISTRAR DATE <u>NOV 3 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | | |
| VS A15 (4) 15M 9/55 | | | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12787

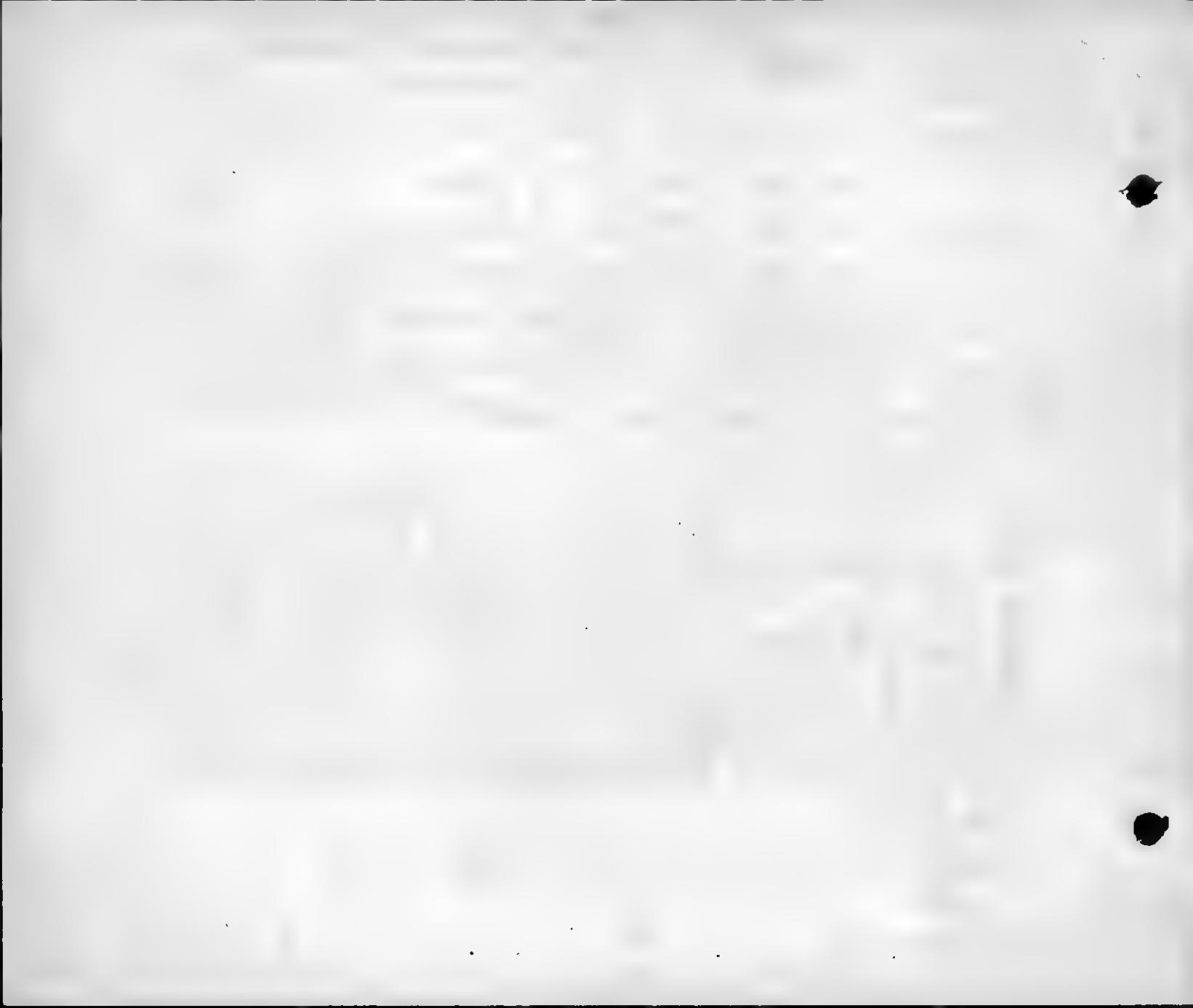
Reg. Dist. No.

12870

| | | | |
|--|-----------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | b. COUNTY <u>Montgomery</u> | |
| c. LENGTH OF STAY IN lb <u>2 1/2 mo</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>733 Silver Ave - apt 515</u> | | d. STREET ADDRESS <u>733 Silver Ave - apt 515</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Clarence Thomas Payne</u> | | 4. DATE OF DEATH <u>Nov 19</u> | |
| First | Middle | Month | Day |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-17-17</u> |
| WIDOWED <input type="checkbox"/> | DIVORCED <input type="checkbox"/> | 9. AGE (In years last birthday) <u>42 yrs.</u> | 10. IF UNDER 1YEAR <u>Months</u> |
| | | 11. IF UNDER 24 HRS. <u>Days</u> | 12. IF UNDER 24 HRS. <u>Hours</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salvager</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Undiscribed Petrol</u> | |
| 10c. BIRTHPLACE (State or foreign country) <u>Ohio</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>John J. Payne</u> | | 14. MOTHER'S MAIDEN NAME <u>Nora Barton</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WW #2</u> | | 16. SOCIAL SECURITY NO. <u>Marguerite H. Payne - Item 2</u> | |
| 17. INFORMANT <u>Marguerite H. Payne - Item 2</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatized Bronchopneumonia</u> | | | |
| DUE TO <u>Obstruction of Gastrointestinal tract</u> | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). <u>Septic fatty degeneration,</u> | | | |
| DUE TO <u>Obstruction of Gastrointestinal tract</u> | | | |
| C (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> <u>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>p. m.</u> <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) <u>(County)</u> <u>(State)</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED <u>11-20-59</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>11/24/59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORIUM <u>ARLINGTON NATIONAL CEMETERY</u> | | 22d. LOCATION (City, town, or county) <u>ARLINGTON, VIRGINIA</u> (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond P. E. Purcell, Inc.</u> | | | |
| ADDRESS <u>SILVER SPRING, MD.</u> | | 24a. REC'D BY REGISTRAR <u>Arthur S. Thorne</u> | |
| DATE <u>NOV 24 '59</u> | | 24b. REGISTRAR'S SIGNATURE | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certifying physician, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
 5M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

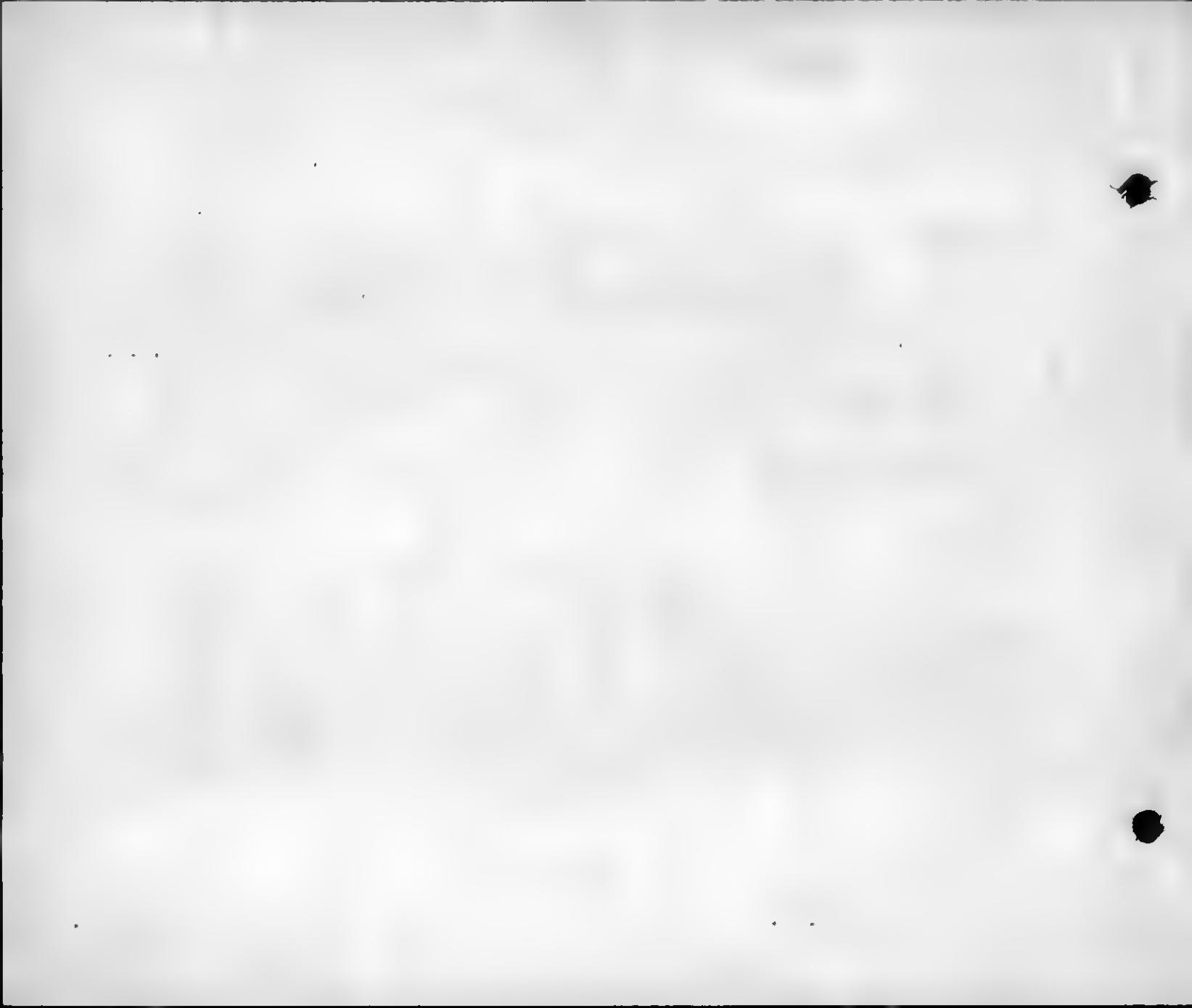
Reg. Dist. No.

12788

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY M ontgomery | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN lb 12 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) S u b u r b a n H o s p i t a l | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47x-9 | |
| 3. NAME OF -DECEASED (Type or print) John R. Pearson | | d. STREET ADDRESS 1318 Sheridan Street N.W. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH February 5, 1911 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Pearson | | 14. MOTHER'S MAIDEN NAME Fitzgough | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Yes | |
| 17. INFORMANT Hosp Record | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 | | myocardial Infarction 1 day | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b) Coronary artery thrombosis | | 1 day | |
| DUE TO c) Arterio sclerosis | | Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on floor at home | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 11-13 1959 | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home | | 20f. (City or town) Washington D.C. | |
| 20g. (County) | | (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <i>Frank J. Borschart</i> | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 11-25-59 |
| EXAMINER'S NAME (Type) FRANK J. Borschart | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) Burial | 22b. DATE THEREOF 11-28-59 | 22c. NAME OF CEMETERY OR CREMATORIUM CHANTILLY | 22d. LOCATION (City, town, or county) (State) Va. |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert J. McGehee</i> | ADDRESS 1870 - G | 24a. REC'D BY REGISTRAR DATE NOV 27 '59 | 24b. REGISTRAR'S SIGNATURE Clayton & Son |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PAA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



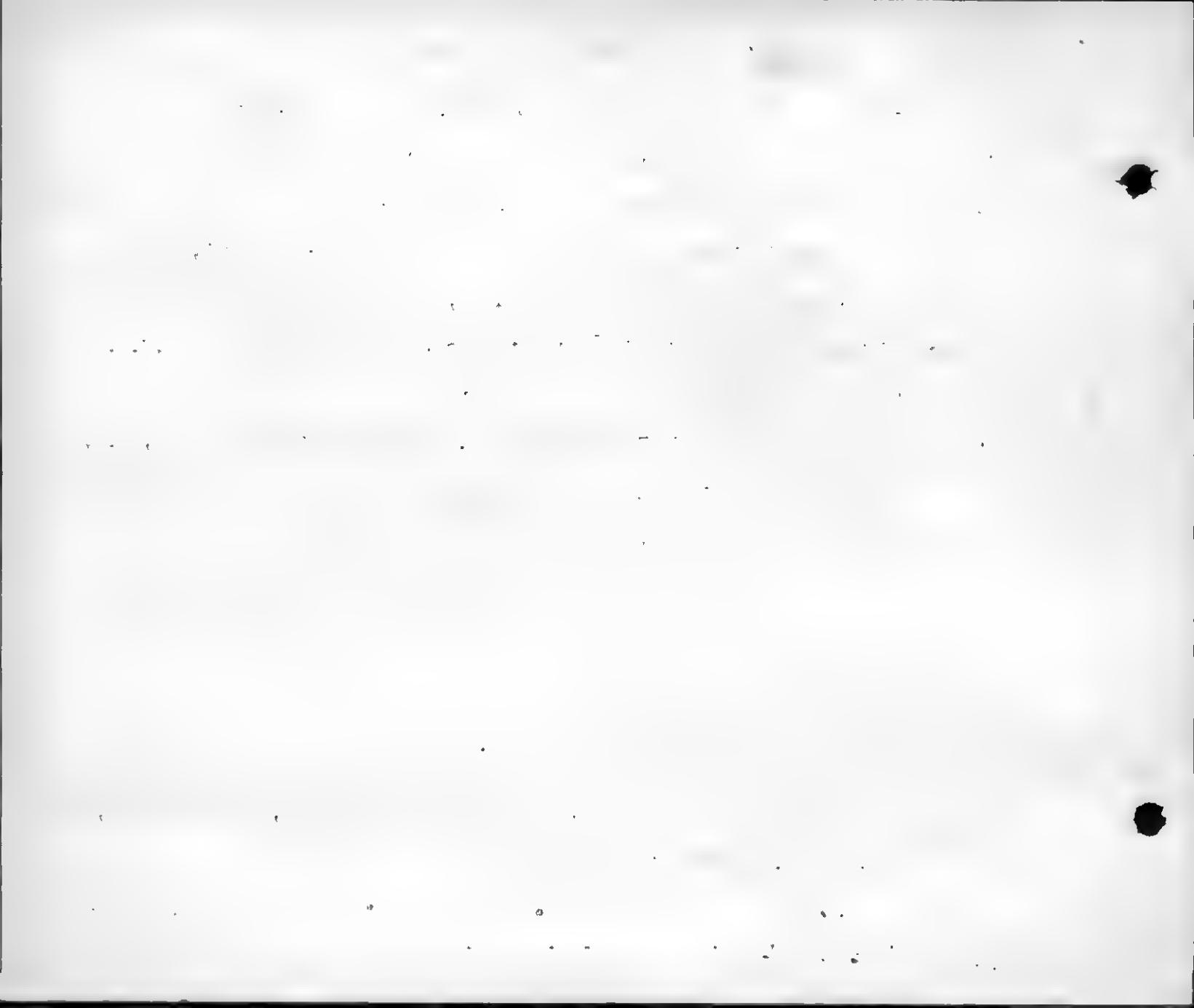
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12783

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | |
|---|----------------------------------|---|--|---|---|---|---------------------------------------|----------------------------------|----------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If instit. on: Residence before admission) a. STATE Maryland | | b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | c. LENGTH OF STAY IN lb 4 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | d. STREET ADDRESS 715 Thayer Ave | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanatorium and Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) John Maxwell Peay | | First | Middle | Last | 4. DATE OF DEATH November 3, 1959 | Month | Day | Year | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Oct. 15, 1890 | | 9. AGE (In years last birthday) 69 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Days | Hours | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Justice of Peace | | 10b. KIND OF BUSINESS OR INDUSTRY Montgomery County, Md. | | 11 BIRTHPLACE (State or foreign country) Georgia | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME unknown Peay | | | | 14 MOTHER'S MAIDEN NAME Isabelle Roach | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 577-09-9568 | | INFORMANT Robert E. Peay | | Address 8516 Greenwood Ave, S.S. Md | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | <i>Cerebral Emboli.</i> | | | | INTERVAL BETWEEN ONSET AND DEATH 1 day | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO | | <i>Generalized Arteriosclerosis.</i> | | | | 2-3 year | | | |
| (c) DUE TO | | | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | Month 19 | Day 3-19 | Year 1959 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) 1030 AM | (County) Silver Spring | (State) Md |
| 21. I certify that I attended the deceased from alive on 11/2 , 19 59 , and that death occurred at 6:30 AM , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) 800 Pershing Drive, Silver Spring, Md | | | | | | | |
| ACTUAL SIGNATURE <i>W.B. Wardrop MD</i> | | DATE SIGNED 11/4/59 | | | | | | | |
| PHYSICIAN'S NAME (Type) William B. Wardrop | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/5/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM PARKLAWN CEMETERY | | 22d. LOCATION (City, town, or county) MONTGOMERY COUNTY, MARYLAND | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. | | ADDRESS SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR NOV 4 '59 | | 24b. REGISTRAR'S SIGNATURE <i>Charles E. Evans</i> | | | |



TO HOSPITAL may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

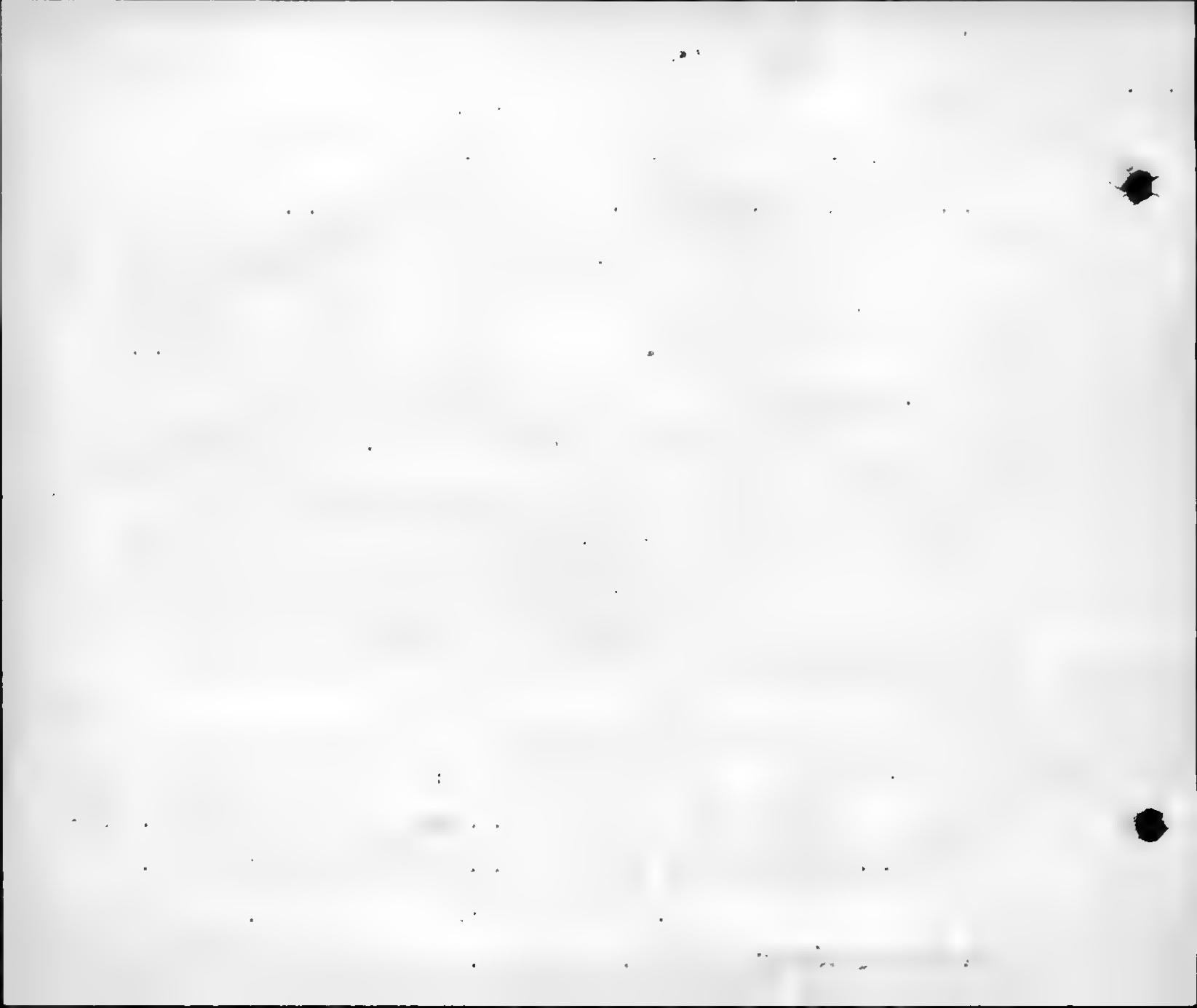
12812

CERTIFICATE OF DEATH

Reg. Dist. No. 215

12750

| | | | | | | | |
|---|----------------------------------|---|--|--|--|---|------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution residence before admission) a. STATE District of Columbia | | b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 1 day | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md. | | | | d. STREET ADDRESS 3317 5th Street S.E. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First James | Middle Francis | Last PERRAULT | 4. DATE OF DEATH November | Month 5 | Day 1959 | Year |
| S. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-17-59 | 9. AGE (In years lost birthday) yrs. 2 | IF UNDER 1 YEAR 2 | IF UNDER 24 HRS 19 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Massachusetts | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Louis F. PERRAULT | | | | 14. MOTHER'S MAIDEN NAME Helen LANNAN | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | INFORMANT (Father) Louis F. Perrault | | Address Same as #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shock and dehydration INTERVAL BETWEEN ONSET AND DEATH 1. day 053.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Neglected upper respiratory infection, 6 days DUE TO (c) Renal Shutdown DUE TO | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5 November, 1959 , to 5 November, 1959 , that I last saw the deceased alive on 5 November, 1959 , and that death occurred at 9:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>G.B. Avery</i> DATE SIGNED 11-5-59 | | | | | | | |
| PHYSICIAN'S NAME (Type) G.B. Avery LT MC USN | | U.S. Naval Hospital, Bethesda Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11-9-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM St. Patrick's Cemetery | | 22d. LOCATION (City, town, or county) Lowell Mass. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert Dempsey</i> | | ADDRESS 1 Ave. Bethesda Md. | | 24a. REC'D BY REGISTRAR Clarence L. Thomas | | 24b. REGISTRAR'S SIGNATURE | |
| VS A1S (4) ISM 9/58 | | DATE NOV 10 '59 | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12813

CERTIFICATE OF DEATH

Reg. Dist. No.

12791

| | | | | | | | | | | | | |
|---|--|---|---|--|---|---|------------------|--|------------------|---|---------------------------|--------------------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE D.C. | | b. COUNTY | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA | | c. LENGTH OF STAY IN 1b 1 week | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | d. STREET ADDRESS 612 Mellon St. S.E. | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First ERNEST | Middle H. | Last PERRY | 4. DATE OF DEATH | Month NOV. | Day 10 | Year 1959 | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE CAU | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 18-1910 | 9. AGE (In years last birthday) 49 yrs. | 10. IF UNDER 1 YEAR / IF UNDER 24 HRS. Months 0 | Days 0 | Hours 0 | Min. 0 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY Construction | | 11. BIRTHPLACE (State or foreign country) White Hall N.Y. | | 12. CITIZEN OF WHAT COUNTRY? A.S.A. | | | | | | |
| 13. FATHER'S NAME Robert Perry | | 14. MOTHER'S MAIDEN NAME Sylvia Blanchard | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO none | | 17. INFORMANT Ethel M. Perry 612 Mellon St. S.E. D.C. | | Address | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) | | Congestive Heart Failure | | | | INTERVAL BETWEEN ONSET AND DEATH 7 days | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1331 1/2 TAPEA ST. W.D.C. | | 20f. (City or town) W.D.C. | (County) W.D.C. | (State) W.D.C. |
| 21. I certify that I attended the deceased from Nov. 3, 1959 to Nov. 9, 1959 , that I last saw the deceased alive on Nov. 9, 1959 , and that death occurred at 3:00 P.M. from the causes and on the date stated above. | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| ACTUAL SIGNATURE W.W. Chambers Co. Inc. | | | | | | | | | | DATE SIGNED Nov. 16, 1959 | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 11/13/59 | | 22b. DATE THEREOF 11/13/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill | | 22d. LOCATION (City, town or county) Bethesda Md. | | (State) MD. | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Inc. | | ADDRESS Washington, D.C. | | 24a. REC'D BY REGISTRAR DATE NOV 16 '59 | | 24b. REGISTRAR'S SIGNATURE Charles S. Howard | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death - Page 2
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12814

CERTIFICATE OF DEATH

12792

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|--|---|---|---------------------------------------|--|-------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Maryland</i> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i> | | b. COUNTY <i>Maryland</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i> | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i> | | d. STREET ADDRESS <i>5006 Dalton Rd.</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First <i>RALPH</i> | Middle <i>FERRY</i> | Last <i>FERRY</i> | 4. DATE OF DEATH | Month NOV. | Day 16, | Year 1959 |
| S. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | B. DATE OF BIRTH <i>Oct. 2, 1884</i> | 9. AGE (In years lost birthday) <i>75 yrs.</i> | IF UNDER 1 YEAR Months <i>0</i> | IF UNDER 24 HRS Days <i>0</i> | Hours <i>0</i> |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>N.Y.</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>New York</i> | | 11. BIRTHPLACE (State or foreign country) <i>D.C.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>Because M. Boyd, 507 Dalton Rd.</i> | |
| 13. FATHER'S NAME <i>JAMES. PERRY</i> | | 14. MOTHER'S MAIDEN NAME <i>Tda. WARD. PERRY</i> | | Address | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT | | INTERVAL BETWEEN ONSET AND DEATH <i>10 day</i> | |
| | | | | | | Years | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO | | Acute myocardial infarction | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO | | General arteriosclerosis | | | | | |
| (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <i>Nov. 6, 1959</i> to <i>present</i> , that I last saw the deceased alive on <i>Nov. 16, 1959</i> , and that death occurred at <i>10 AM</i> , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) <i>Abrasions of forehead and small laceration</i> M.D. <i>had nothing to do with death. Talked to coroner regarding it.</i> 4400 - 49th St. N.W. Washington, D.C. | | | | | |
| ACTUAL SIGNATURE <i>C.P. Ryland</i> | | DATE SIGNED <i>12/1/59</i> | | | | | |
| PHYSICIAN'S NAME (Type) <i>C.P. RYLAND, M.D.</i> | | | | | | | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) | | 22b. DATE THEREOF <i>11/1/59</i> | | 22c. NAME OF CEMETERY OR CREMATORIUM <i>Lewis Cemetery</i> | | 22d. LOCATION (City, town, or county) <i>Washington, D.C.</i> (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Kraus</i> | | ADDRESS <i>100 Franklin Home Dr.</i> | | 24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i> DATE <i>NOV 18 '59</i> | | 24b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12793

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK | c. LENGTH OF STAY IN 1b 1 mth | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SANITARIUM | | d. STREET ADDRESS 7504 WILDWOOD DRIVE | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First RUTH | Middle AGNES | Last PICARD |
| 4. DATE OF DEATH | Month NOVEMBER | Day 2 | Year 1939 |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH SEPT 4, 1887 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | 11. BIRTHPLACE (State or foreign country) NY |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME WILLIS KNOTT | | 14. MOTHER'S MAIDEN NAME MARY FITZGIBBONS | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tel. no. or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Mrs DANIEL HAMMOND, 7504 WILDWOOD DR |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephritis DUE TO (c) | | Address TOK. TR. MD. INTERVAL BETWEEN ONSET AND DEATH 1 week 3 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 100 Longfellow STN. W Wash. DC. 11-2-39 | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from June , 19 49 , to Nov 2 , 19 39 , that I last saw the deceased alive on Nov 2 , 19 39 , and that death occurred at 10:30 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE PHYSICIAN'S NAME (TYPE) | ADDRESS (Street, city or town, state) 100 Longfellow STN. W Wash. DC. 11-2-39 DATE SIGNED Simon C. Weiner M.D. Simon C. WEINER | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF NOV 6, 1939 | 22c. NAME OF CEMETERY OR CREMATORIUM St. Michael's Cemetery | 22d. LOCATION (City, town, or county) Westerly, Hyde Island (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE John J. Weider | ADDRESS 1415 1/2 St. DC | 24a. REC'D BY REGISTRAR DATE NOV 4 '39 | 24b. REGISTRAR'S SIGNATURE Oscar S. Kraus |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12689

CERTIFICATE OF DEATH

Reg. Dist. No.

12794

| | | | |
|---|------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Delaware</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TAKOMA PARK</i> | | c. LENGTH OF STAY IN 1b <i>3 1/2 yrs.</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>RAILS Nursing Home</i> | | e. STREET ADDRESS <i>Route #1, Box 80</i> | |
| 3. NAME OF DECEASED (Type or print) <i>SARAH Jane Reed</i> | | 4. DATE OF DEATH Month <i>Nov. 25</i> | Year <i>1959</i> |
| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Nov. 5, 1876</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>None</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>West Virginia</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Benjamin DuMire</i> | | 14. MOTHER'S MAIDEN NAME <i>Mariot Ark</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>None</i> | |
| 17. INFORMANT <i>Mrs. Nelle W. Livingston</i> | | Address <i>9001 Miles St., Silver Spring</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral vascular accident</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> | |
| DUE TO <i>743X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Generalized arteriosclerosis 37 years</i> | | DUE TO <i>Hypertensive cardiovascular disease 37 years</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>4/6</i> , 1956, to <i>11/25</i> , 1959, that I last saw the deceased alive on <i>Nov. 23</i> , 1959, and that death occurred at <i>4:50 A.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Wallace N. Mock</i> | | ADDRESS (Street, city or town, state) <i>M.D. 7701 Carroll Avenue 11/25/59</i> | |
| PHYSICIAN'S NAME (Type) <i>Wallace N. Mock MD Takoma Park 12, Md.</i> | | DATE SIGNED <i>11/25/59</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Nov. 28, 1959</i> | | 22b. DATE THEREOF <i>Nov. 28, 1959</i> | |
| 22c. NAME OF CEMETERY OR CREMATORIUM <i>Graceland Cemetery</i> | | 22d. LOCATION (City, town, or county) (State) <i>Wilmington, Delaware</i> | |
| 23. FUNERAL-DIRECTOR'S SIGNATURE <i>J. Arthur Waites, 254 Carroll St NW</i> | | 24a. REC'D BY REGISTRAR DATE NOV 27 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE <i>G. L. S. Hause</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

[Handwritten mark resembling a signature]

DOCTOR: The law requires that the death certificate be executed within 24 hours after death.

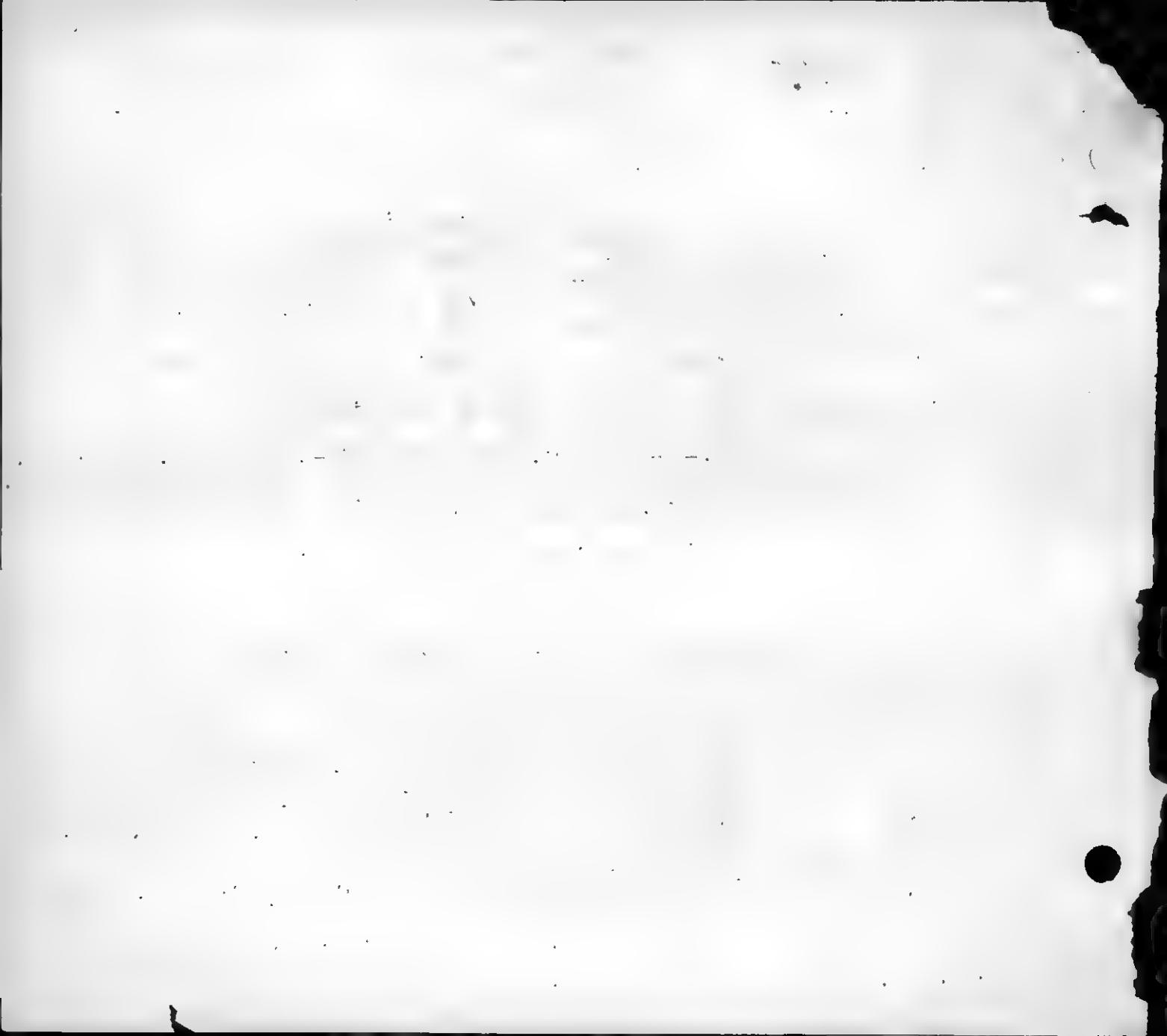
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12795

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|--|---|--|------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND Maryland | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 3½ days | | b. COUNTY Montgomery | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | | | |
| 3. NAME OF DECEASED (Type or print) William | | | | First William | Middle Aldia | Last Ricketts | 4. DATE OF DEATH Month 11 Day 19 Year 19 59 |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 2/29/02 | | 9. AGE (In years lost / today) 57 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months 8 Days 20 Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME William Augustus Ricketts | | | | 14. MOTHER'S MAIDEN NAME Mary Susan Ricketts | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO 212-14-8432 | | INFORMANT Mrs. Helen Bogdanski - 407 Carl St., Rockville, | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 002X (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) Tuberculosis, especially left lung | | | | | | | |
| INTERVAL BETWEEN MD. ONSET AND DEATH 3 hours | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Injury occurred at home | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 11-15-1959 to 11-19-1959 , that I last saw the deceased alive on 11-19-1959 , and that death occurred at 3:15 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE George A. Gray, M.D. | | ADDRESS (Street, city or town, state) 4422 East West Hwy, Bethesda, Md. | | | | | |
| PHYSICIAN'S NAME (Type) George A. Gray, M.D. | | DATE SIGNED 11/20/59 | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/22/59 | | 22c. NAME OF CEMETERY OR CREMATORIAL Potomac Church Cemetery | | 22d. LOCATION (City, town, or county) (State) Potomac, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Maryland | | 24a. REC'D BY REGISTRAR DATE NOV 23 '59 | | 24b. REGISTRAR'S SIGNATURE Charles S. Kincaid | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12690

CERTIFICATE OF DEATH

Reg. Dist. No.

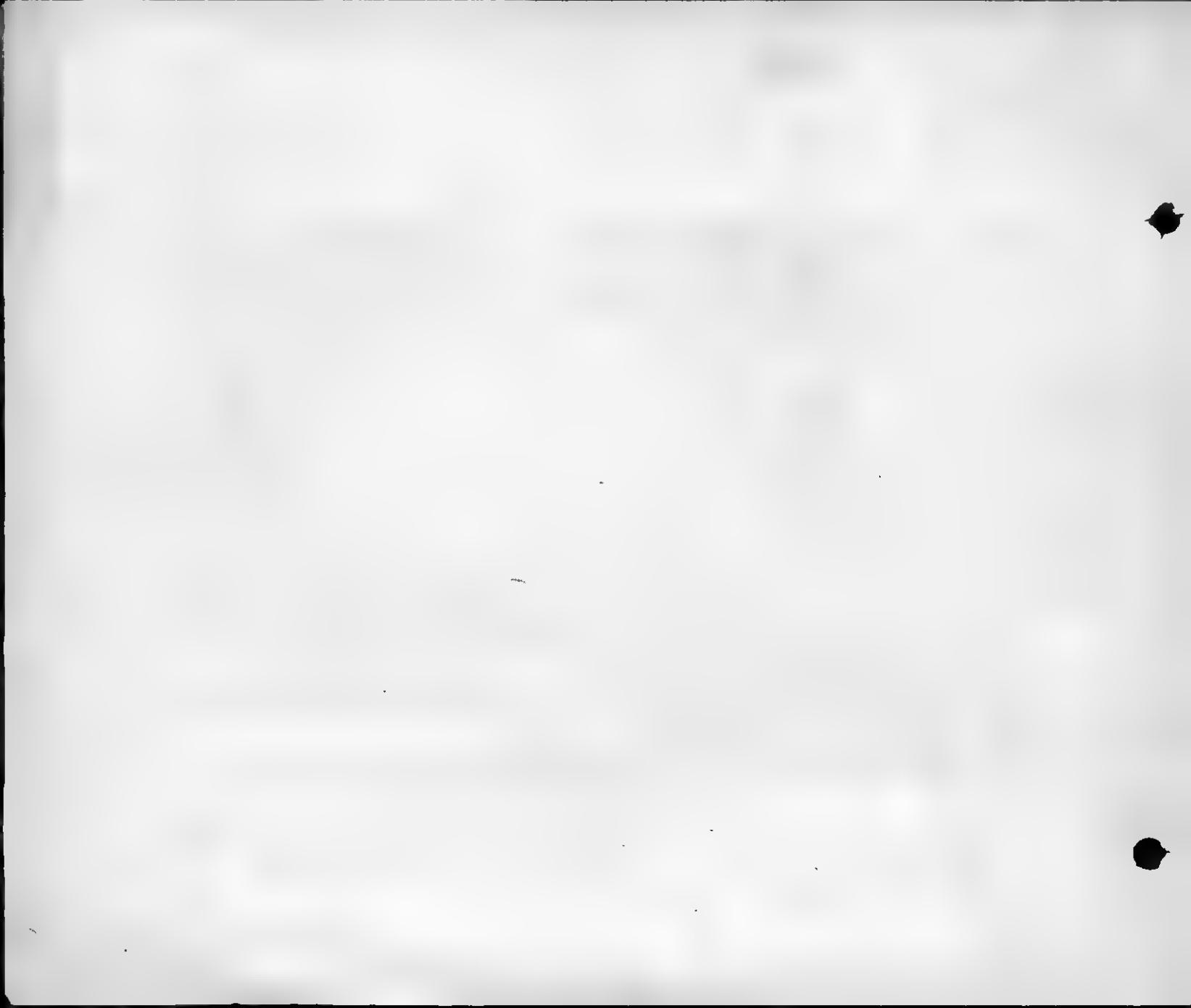
12796

| | | | | | | | | | |
|---|--|---|---|--|---|---|------------------------------------|--------------------------|------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i> | | b. COUNTY <i>b. County</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | | c. LENGTH OF STAY IN 1b <i>2/15/59 - 11/2/59</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i> | | d. STREET ADDRESS <i>3700 39th St., N.W.</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Washington Spiritusium & Hospital</i> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <i>Sarah (NMN)</i> | | First | Middle | Last | 4. DATE OF DEATH <i>NOV 2 1959</i> | Month | Day | Year | |
| 5. SEX <i>f</i> | | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>3-8-89</i> | 9. AGE (In years last birthday) <i>10 yrs</i> | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS Hours | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Russia</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>Russia</i> | | | |
| 13. FATHER'S NAME <i>Solomon Ritzewberg</i> | | 14. MOTHER'S MAIDEN NAME <i>Mollie Daitch</i> | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO <i>UNKNOWN</i> | | 17. INFORMANT <i>MARTIN WATMAN</i> | | Address <i>3700-39th-Nicel DC</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | CEREBRAL THROMBOSIS | | | | INTERVAL BETWEEN ONSET AND DEATH <i>6 HOURS</i> | | | |
| CEREBRAL ARTERIOSCLEROSIS | | | | | | 1 MONTH | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>CONGESTIVE HEART FAILURE</i> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>None</i> | | | | | | | |
| 20c. TIME OF INJURY Hour o.m. p.m. | | Month 19 | Day | Year | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i> | 20f. (City or town) <i>None</i> | (County) <i>None</i> | (State) <i>None</i> |
| 21. I certify that I attended the deceased from <i>2/15</i> , 19 <i>59</i> , to <i>11/2</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>11/2</i> , 19 <i>59</i> , and that death occurred at <i>8 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Samuel V. N. Sugar, M.D.</i> ADDRESS (Street, city or town, state) <i>4300 Maywood Drive, Mt Rainier, Md.</i> DATE SIGNED <i>11/2/59</i> | | | | | | | | | |
| 22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>11/4/59</i> | | 22c. NAME OF CEMETERY OR CREMATORIUM <i>Nat'l Mem. Park</i> | | 22d. LOCATION (City, town, or county) <i>Bethesda</i> | | (State) <i>MD</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Goldberg & Son Funeral Home</i> | | ADDRESS <i>4217 Rockville Rd</i> | | 24a. REC'D BY REGISTRAR DATE <i>NOV 5 '59</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



12797

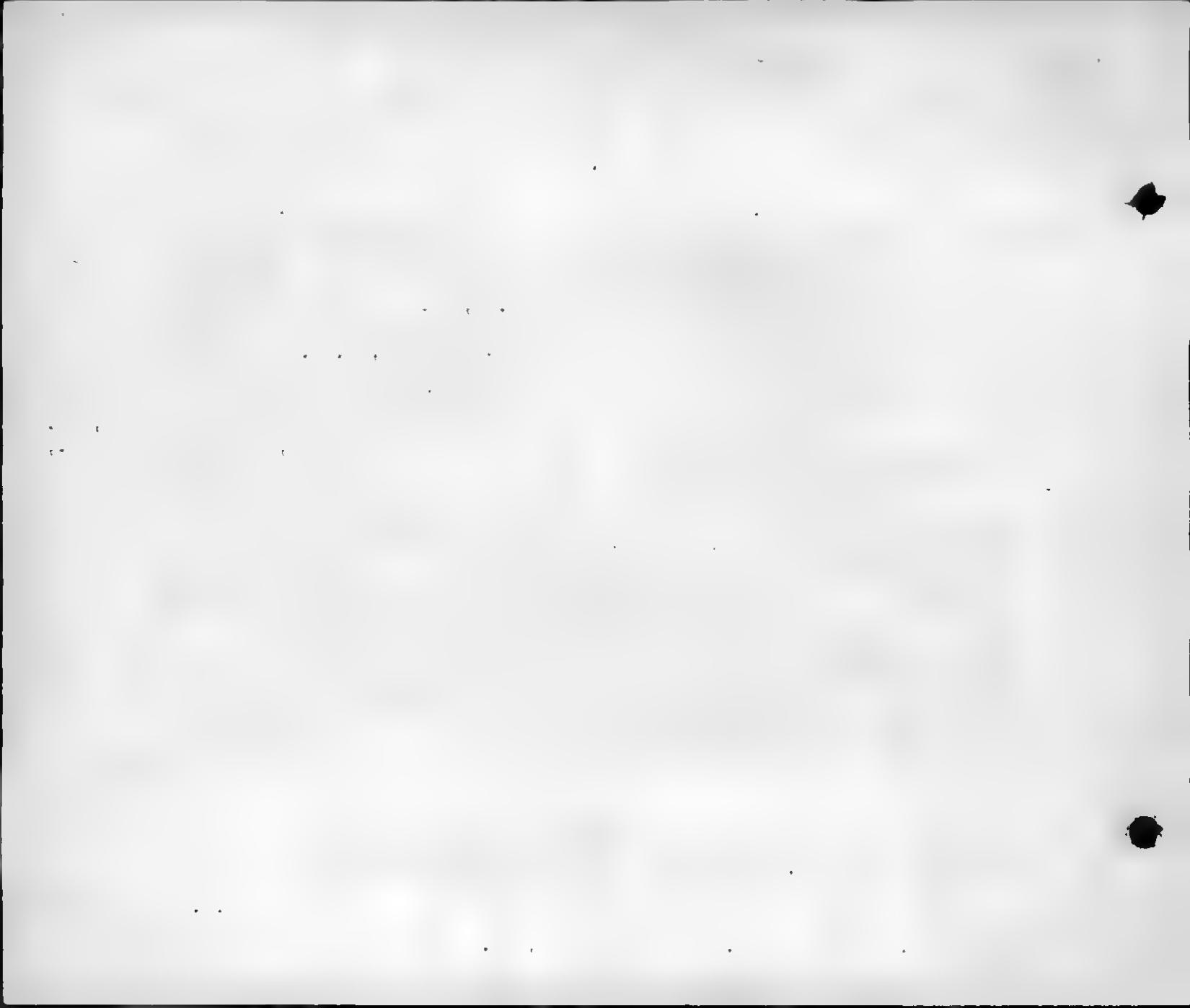
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | |
|--|----------------------------------|---|--|--|--|---|--|------------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND | | b. COUNTY MONTGOMERY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON | | c. LENGTH OF STAY IN 1b 50 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON | | d. STREET ADDRESS 3942 WASHINGTON ST. | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3942 WASHINGTON ST. | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF RACHEL DECEASED (Type or print) VIRGINIA WAUGH RONSAVILLE | | First | Middle | Last | 4. DATE OF DEATH Month NOVEMBER 8 | Day | Year 1959 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH FEB. 22, 1865 | 9. AGE (In years last birthday) 94 | 10. IF UNDER 1 YEAR Months 0 | Days 0 | 11. IF UNDER 24 HRS Hours 0 | Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER retired | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | 11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C. | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME JAMES EDWIN WAUGH | | 14. MOTHER'S MAIDEN NAME SARAH VICTORIA MCKELDEN | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT MISS VIRGINIA RONSAVILLE, 3942 Washington St. | | Address Kensington, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Cerebral Vascula accident | | | | 12 hrs | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) Cardio-Vascular renal disease | | | | 17 yrs | | |
| DUE TO | | | | | | | | |
| (b) DUE TO | | | | | | | | |
| (c) DUE TO | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on bed room floor - Semibdy | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE. <i>Frank J. Broschart</i> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 11-9-59 | | |
| EXAMINER'S NAME (Type) FRANK J. BROSCART | | 22c. NAME OF CEMETERY OR CREMATORIAL ROCK CREEK CEMETERY | | 22d. LOCATION (City, town, or county) WASHINGTON, D.C. | | (State) | | |
| 22e. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22f. DATE THEREOF 11/12/59 | | 24a. REC'D BY REGISTRAR DATE NOV 10 '59 | | 24b. REGISTRAR'S SIGNATURE Frank | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY INC. | | ADDRESS SILVER SPRING, MD. | | | | | | |
| Raymond A. Ziska. | | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11 & 12 Film G252 11/18/59 iwk

CERTIFICATE OF DEATH

12798

Reg. Dist. No.

| | | | | | |
|---|-----------------------------------|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>District of Columbia</i> b. COUNTY <i>District of Columbia</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> | | c. LENGTH OF STAY IN 1b <i>2 mos 25 days</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rosemont Sanitarium - Hospital</i> | | d. STREET ADDRESS <i>6013 Eastern Ave. N.E.</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First <i>ANNA</i> | Middle <i>MARIE</i> | Last <i>Rouleau</i> | 4. DATE OF DEATH <i>Nov. 5</i> | Month Day Year Year |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>Wh. Te</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Nov. 18, 1878</i> | 9. AGE (In years last birthday) <i>80</i> | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i> | | 11. BIRTHPLACE (State or foreign country) <i>Philadelphia, Pa.</i> | |
| | | | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | |
| 13. FATHER'S NAME <i>Thomas Lillard</i> | | 14. MOTHER'S MAIDEN NAME <i>Zentkewson</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>None</i> | | 17. INFORMANT Address <i>Mrs. Anna Lillard - 6013 - Eastern Ave</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) <i>UREMIC</i> <i>CERAL FAILURE</i> <i>GERIC ARTERIOSCLEROSIS</i> | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH <i>1-2 days</i> <i>2-3 days</i> <i>10+ years</i> | | | | | |
| Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>DIABETES MELLITUS</i> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Oct 18, 1959</i> to <i>Nov 5, 1959</i> that I last saw the deceased alive on <i>Oct 4, 1959</i> , and that death occurred at <i>3:30 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Charles J. Savarese, M.D.</i> ADDRESS (Street, city or town, state) <i>4891 Lancaster St., Philadelphia, Penn.</i> DATE SIGNED <i>11/5/59</i> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 22b. DATE THEREOF <i>Nov. 9, 1959</i> | | 22c. NAME OF CEMETERY OR CREMATORIUM <i>Holy Sepulcher Cemetery Philadelphia, Penn.</i> | |
| 22d. LOCATION (City, town, or county) (State) | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Co.</i> | | 24. ADDRESS <i>1400 Chapin St., N.Y.C.</i> | | 25. REC'D BY REGISTRAR DATE <i>NOV 9 '59</i> | |
| | | | | 26. REGISTRAR'S SIGNATURE <i>Ellen S. Moore</i> | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)
1955



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12799

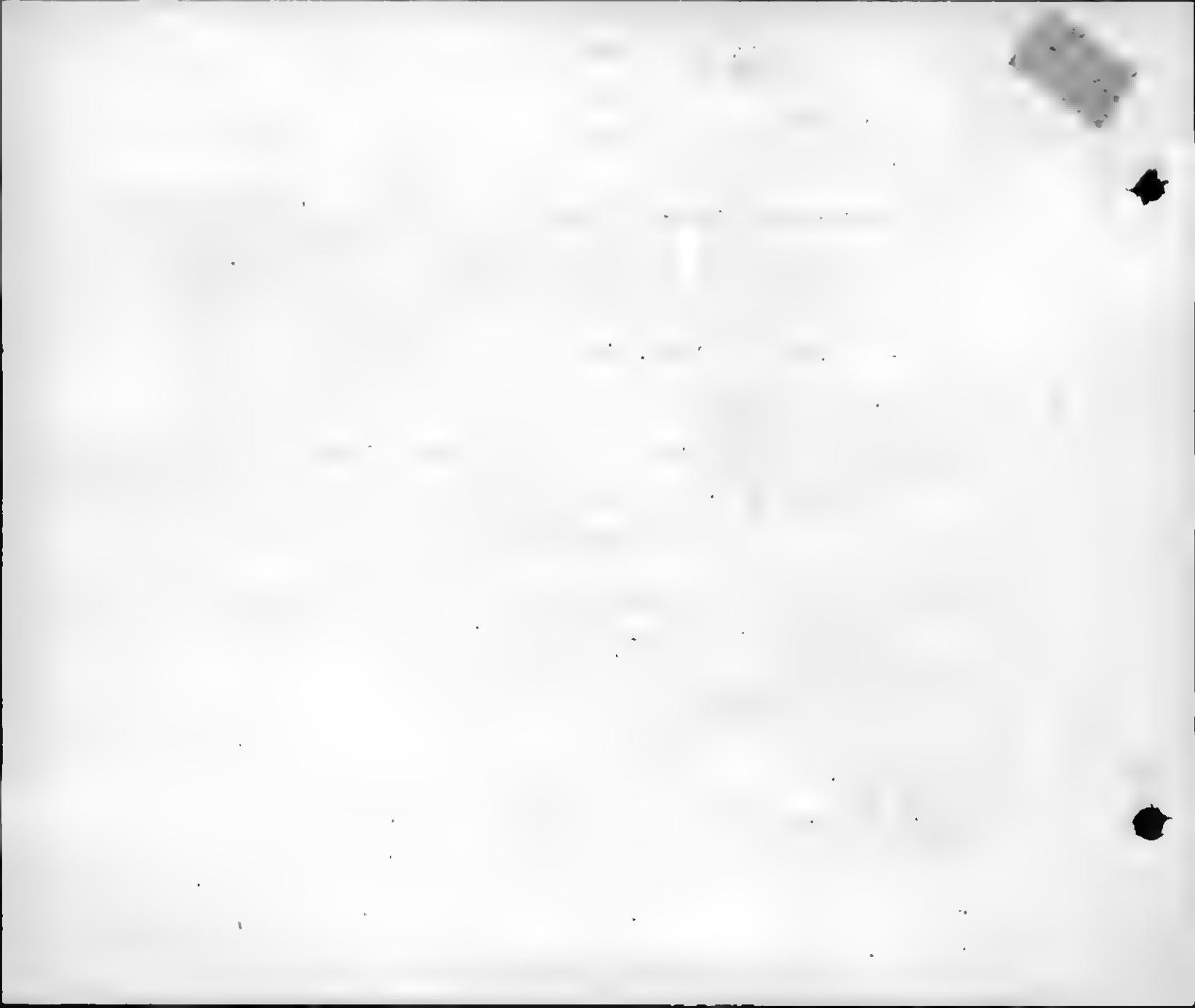
CERTIFICATE OF DEATH

Reg. Dist. No.

12818

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admis on) a. STATE | |
| Montgomery | | Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN lb | |
| Garrett Park | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| 10807 Kenilworth Avenue | | X Garrett Park | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle |
| | | Ruth | E |
| 4. DATE OF DEATH | | Month | Day |
| | | Nov. | 11 |
| 5. SEX | | 5. COLOR OR RACE | 6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> |
| Female | | White | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 7. DATE OF BIRTH | | 8. AGE (In years last birthday) | 9. IF UNDER 1 YEAR Months Days Hours Min. |
| 5/4/1874 | | 85 yrs | 6 7 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| Teacher-retired | | Education | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Virginia | | US | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| Benjamin L Rucker | | Sally Parks | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. INFORMANT Address | |
| No | | None Clara M Rucker-sister-same as 2d | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | |
| 421.1 Due to Cerebral hemorrhage INTERVAL BETWEEN ONSET AND DEATH 1 day | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Hypertensive arterio sclerosis Heart Disease | | | |
| Due to (c) | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| Coronary heart disease | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 1950, to Nov. 11, 1959, that I last saw the deceased alive on Nov. 11, 1959, and that death occurred at 10 AM, from the causes and on the date stated above. | | | |
| ADDRESS (Street, city or town, state) | | | |
| DATE SIGNED 11/14/59 | | | |
| ACTUAL SIGNATURE <i>Jessie Marion Bankhead</i> | | M.D. 9241 Col. Blvd. | |
| PHYSICIAN'S NAME (Type) J. Marion Bankhead | | Silver Spring, Md. | |
| 22a. BUR. AL. CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/14/59 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM Rockville Cemetery | | 22d. LOCATION (City, town, or county) Rockville, Maryland (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Maryland | |
| 24a. REC'D BY REGISTRAR DATE NOV 13 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur & Krause | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12819

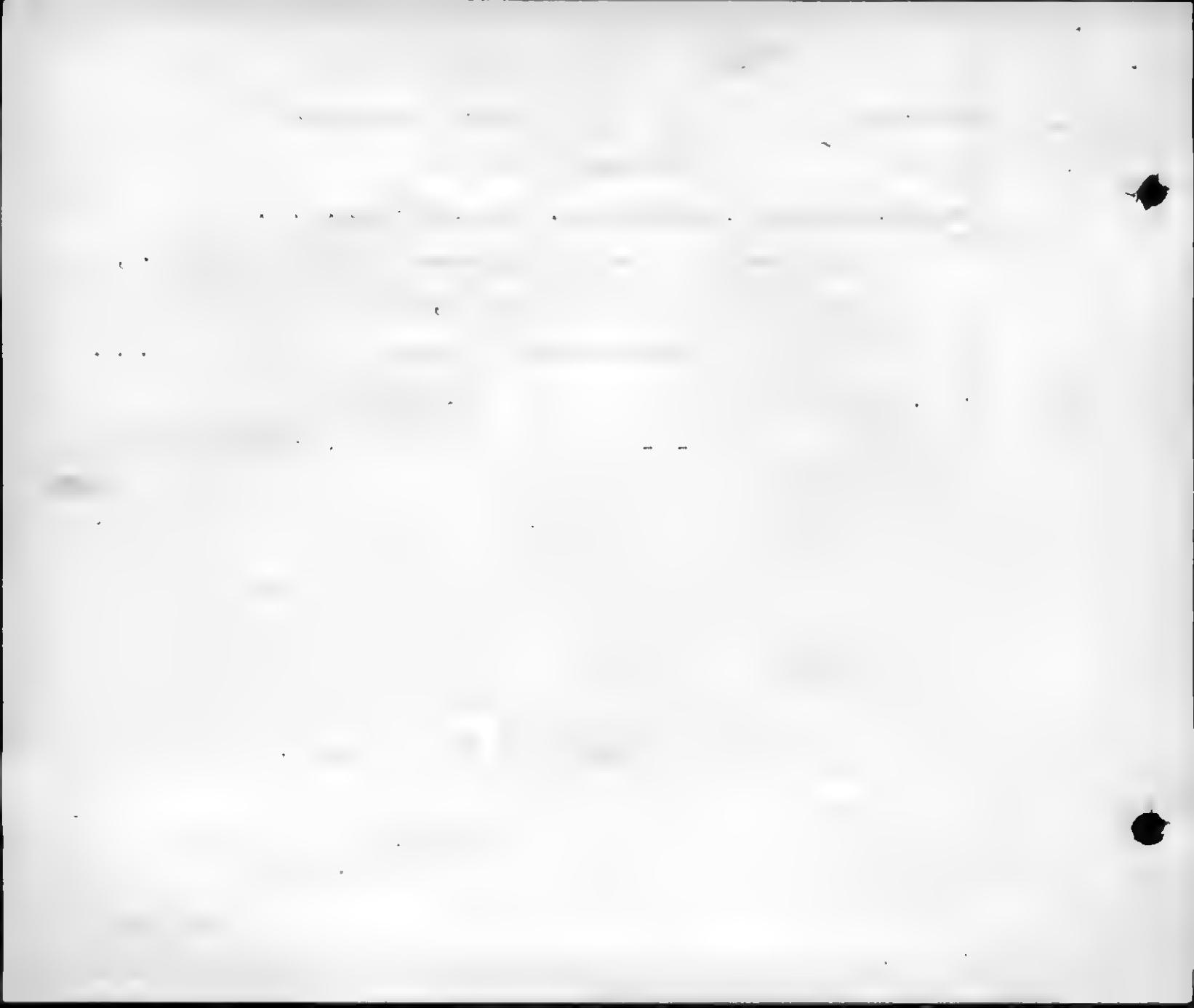
CERTIFICATE OF DEATH

Reg. Dist. No.

12800

TO HOSPITAL may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|---|--|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE District of Columbia | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN lb 11 days | | b. COUNTY | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | |
| 3. NAME OF DECEASED (Type or print) Fred | | First | Middle | Lost | 4. DATE OF DEATH November 23, 1959 |
| | | | | Month | Day Year |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 27, 1894 | 9. AGE (In years last birthday) 65 yrs. |
| 10a. US AL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman | | 10b. KIND OF BUSINESS OR INDUSTRY Merchant Marine | | 11. BIRTHPLACE (State or foreign country) Sweden | |
| 13. FATHER'S NAME John A. Rylander | | 14. MOTHER'S MAIDEN NAME Christina Waldo | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 554-18-4822 | | INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 | | Acute myocardial infarction | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) | | DUE TO Severe generalized atherosclerosis | | | |
| (c) | | DUE TO | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | INTERVAL BETWEEN ONSET AND DEATH 3 days | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) The Clinical Center | (County) (State) |
| 21. I certify that I attended the deceased from November 12, 1959 , to November 23, 1959 , that I last saw the deceased alive on November 23, 1959 , and that death occurred at 6:00 AM , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) National Institutes of Health | | | |
| ACTUAL SIGNATURE Victor W. Sidel | | DATE SIGNED 11-23-59 | | | |
| PHYSICIAN'S NAME (Type) Victor W. Sidel, M.D. | | M.D. The Clinical Center | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 11/25/59 | 22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory | 22d. LOCATION (City, town, or county) Suitland, Maryland | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Maryland | 24a. REC'D BY REGISTRAR NOV 27 '59 | 24b. REGISTRAR'S SIGNATURE Julia L. Haas | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12820

CERTIFICATE OF DEATH

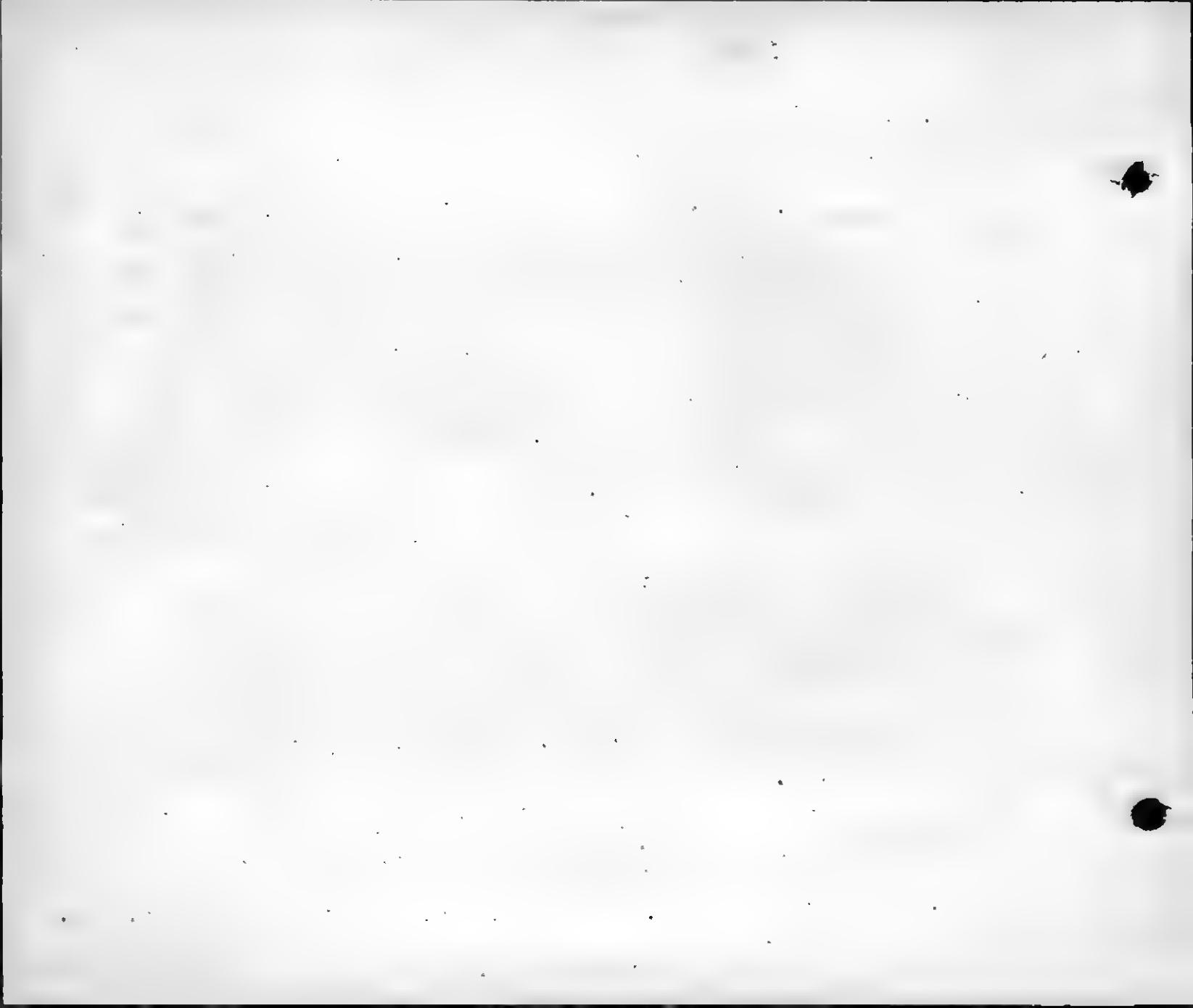
Reg. Dist. No.

12821

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BETHESDA</i> | | c. LENGTH OF STAY IN 1b <i>3 HRS.</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>SUBURBAN HOSPITAL</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First <i>CHARLES</i> | Middle <i>SAMUEL</i> | Last <i>SCHERMERHORN</i> |
| 4. DATE OF DEATH <i>11 15 1959</i> | Month <i>11</i> | Day <i>15</i> | Year <i>1959</i> |
| 5. SEX <i>MALE</i> | 6. COLOR OR RACE <i>WHITE</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>1/13/1889</i> |
| 9. AGE (In years last birthday) <i>70 yrs.</i> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>PRESIDENT OF ART SHOP</i> | 11. KIND OF BUSINESS OR INDUSTRY <i>ART</i> | 12. BIRTHPLACE (State or foreign country) <i>NEW YORK</i> |
| 13. FATHER'S NAME <i>EDWARD SAMUEL SCHERMERHORN</i> | 14. MOTHER'S MAIDEN NAME <i>BELL</i> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> | 16. SOCIAL SECURITY NO. | INFORMANT <i>DOROTHY (WIFE)</i> | Address <i>SAME AS ABOVE</i> |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | |
| 42.1 DUE TO <i>Acute Myocardial infarction</i> | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Acute Coronary Occlusion</i> | | | |
| DUE TO <i>Altered selective heart disease</i> | | | |
| INTERVAL BETWEEN ONSET AND DEATH <i>5 hours</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>August 1959 to October 13, 1959</i> |
| 20f. (City or town) <i>August 1959 to October 13, 1959</i> | | (County) <i>Prince Georges Co.</i> | |
| | | (State) <i>Md.</i> | |
| 21. I certify that I attended the deceased from <i>August 1959 to October 13, 1959</i> that I last saw the deceased alive on <i>November 14, 1959</i> and that death occurred at <i>4:15 AM</i> , from the causes and on the date stated above. | | | |
| ADDRESS (Street, city or town, state) <i>3701 Roger Blvd., Wash. 8, D.C.</i> | | | |
| DATE SIGNED <i>11-15-59</i> | | | |
| ACTUAL SIGNATURE <i>Roger L. K. Jr.</i> | | | |
| PHYSICIAN'S NAME (Type) <i>Roger L. K. Jr., M.D.</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL <i>burial</i> | 22b. DATE THEREOF <i>11/17/59</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i> | 22d. LOCATION (City, town, or county) <i>Prince Georges Co., Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>S. H. Jones Co.</i> | ADDRESS <i>2701-14 St. N.W. Washington, D. C.</i> | 24a. REC'D BY REGISTRAR <i>NOV 17 '59</i> | 24b. REGISTRAR'S SIGNATURE <i>Charles & Kraus</i> |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12802

MOV'D 12821 COUNTY

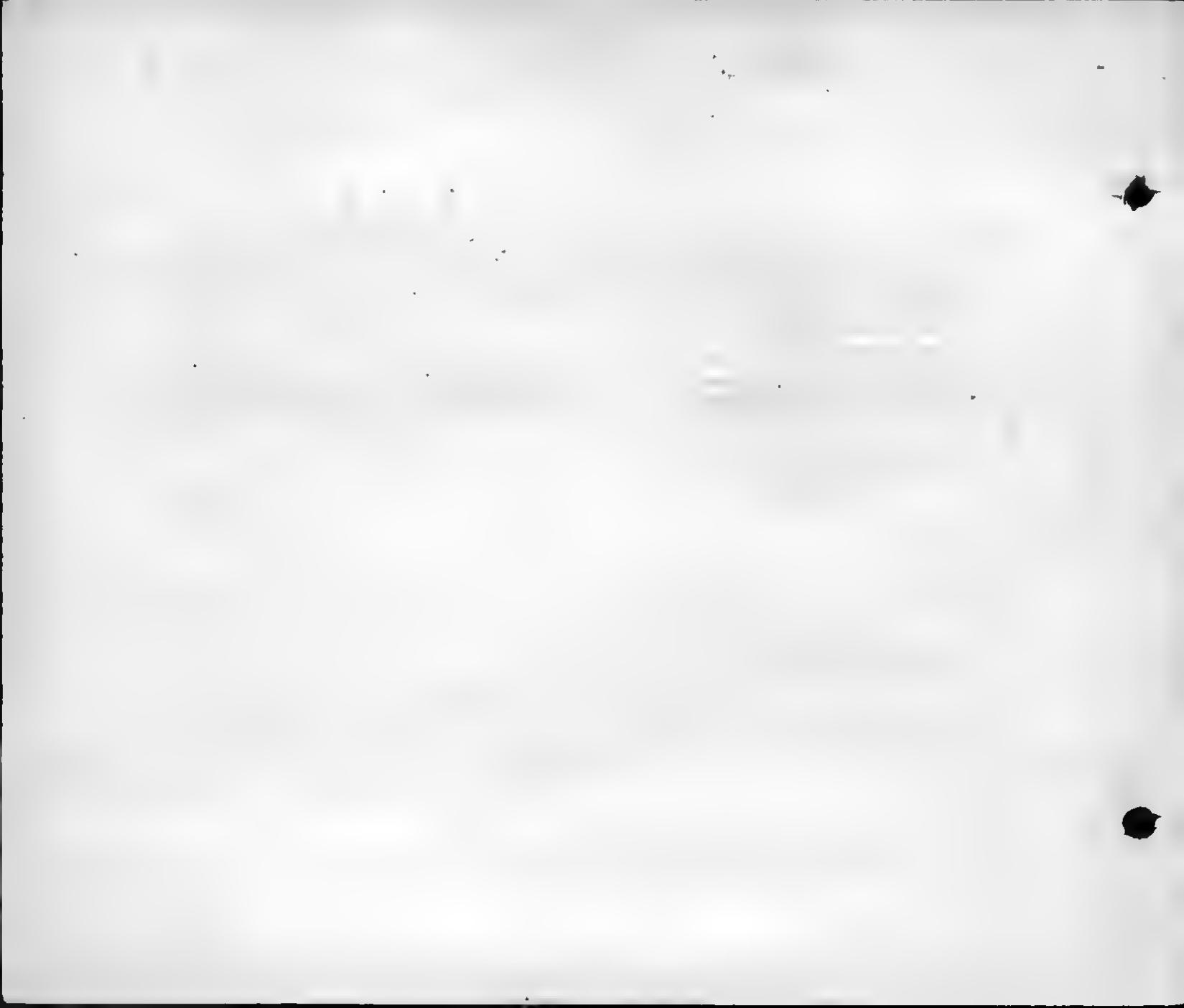
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|---|-------------------------|
| 1. PLACE OF DEATH a. COUNTY Resmoy Sanitarium 5721 Grosve nor-Lane Bethesda MARYLAND | | 2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE Bethesda Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] RURAL and the nearest town Bethesda | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL [If not in hospital, give street address] OR INSTITUTION Resmoy Sanitarium | | d. STREET ADDRESS 7311 Delfield st. | |
| 3. NAME OF DECEASED (Type or print) Miss Nona Elizabeth Scott | | 4. DATE OF DEATH Nov. 19 | Month Day Year 19 59 |
| 5. SEX Female White | | 6. COLOR OR RACE | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH Nov. 26, 1865 | |
| WIDOWED <input type="checkbox"/> | | DIVORCED <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] Government Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) England | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME James Scott | | 14. MOTHER'S MAIDEN NAME Annie Elizabeth Atwell | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Capt James Scott Jr., Chevy Chase Md | | Address 7311 Delfield St Chevy Chase Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.0 | | 2 hrs | |
| DUE TO | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) | | Congestive heart failure | |
| DUE TO | | 3-4 weeks | |
| (c) Arteriosclerotic heart disease | | 20 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | |
| 20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| ACTUAL SIGNATURE Charles J. Savarese, Jr., M.D. | | 4690 BATTERY LN 11/19/59 | |
| PHYSICIAN'S NAME (Type) CHARLES J. SAVARESE, JR., M.D. | | BETHESDA, MD. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/21/59 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL Woodlawn | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers (L.C.) ADDRESS 1451 Chapin St NW, Wash. DC | | 24a. REC'D BY REGISTRAR DATE NOV 20 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE Esther S. Kraus | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reprove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



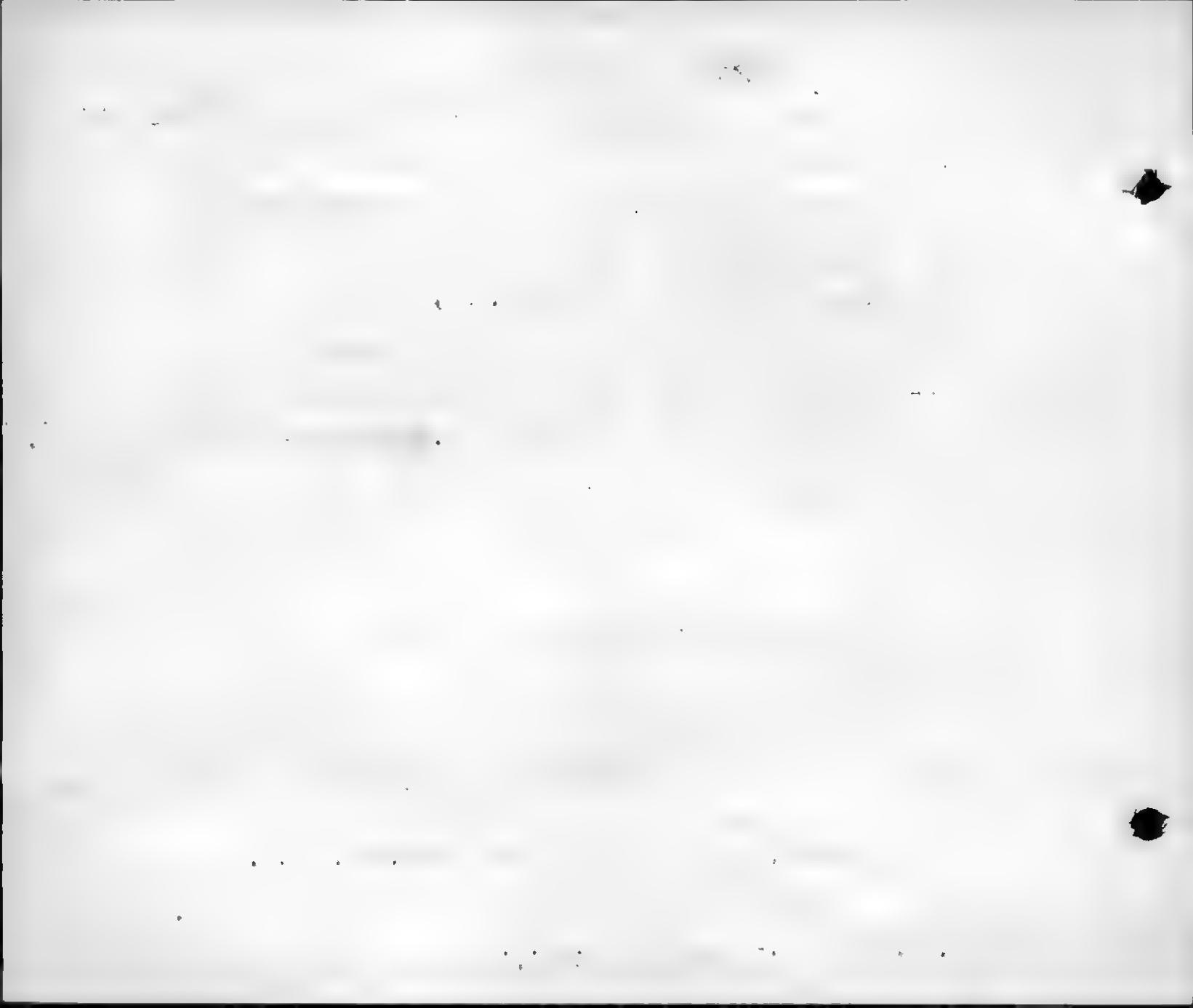
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12803

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH o. COUNTY MONTGOMERY | | 2. USUAL RESIDENCE (Where deceased lived - If institution: Res dence before admission) o. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE | | b. COUNTY Montgomery | |
| c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5201 SARATOGA AVENUE | | d. STREET ADDRESS 5201 Saratoga Avenue | |
| e. IS RESIDENCE ON A FARM? YES. <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First LYDIA | Middle F | Last SCRIVENER |
| 4. DATE OF DEATH | Month 11 | Day 3 | Year 1959 |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 20, 1879 |
| 9. AGE (In years from birthday) 80 yrs. | | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Days 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) South Carolina | | 12. CITIZEN OF WHAT COUNTRY? U. S. A | |
| 13. FATHER'S NAME -- Emmons | | 14. MOTHER'S MAIDEN NAME Lucy Conant | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | 16. SOCIAL SECURITY NO. no | INFORMANT Milton E. Scriwener | Address Chevy Chase, Md. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c) | | INTERVAL BETWEEN ONSET AND DEATH 4 day | |
| DUE TO Congestive Heart failure | | | |
| DUE TO Coronary heart disease Myocardial infarction | | 7 day | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION G.VEN IN PART 1(a) Arteriosclerosis Obliterans - Diabetes Mellitus | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month 19 | Day 19 | Year 1959 |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) 1150 Conn. Ave., N.W. | (County) (State) |
| 21. I certify that I attended the deceased from 8-15 , 19 57 , to 11-3 , 19 59 that I last saw the deceased alive on 10-31-57 , 19 57 , and that death occurred at 4:00 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Andrew G. Prandoni | ADDRESS (Street, city or town, state) 1150 Conn. Ave., N.W. | | |
| PHYSICIAN'S NAME (Type) Andrew G. Prandoni | DATE SIGNED 11-5-59 | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 11/5/59 | 22c. NAME OF CEMETERY OR CREMATORIUM Glenwood Cemetery | 22d. LOCATION (City, town, or county) Washington, D.C. |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. - 2901 14th St. N.W. Washington 9; B.C. | ADDRESS 14th St. N.W. Washington 9; B.C. | 24a. REC'D BY REGISTRAR NOV 4 '59 | 24b. REGISTRAR'S SIGNATURE Arthur S. Tenner |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12814

CERTIFICATE OF DEATH

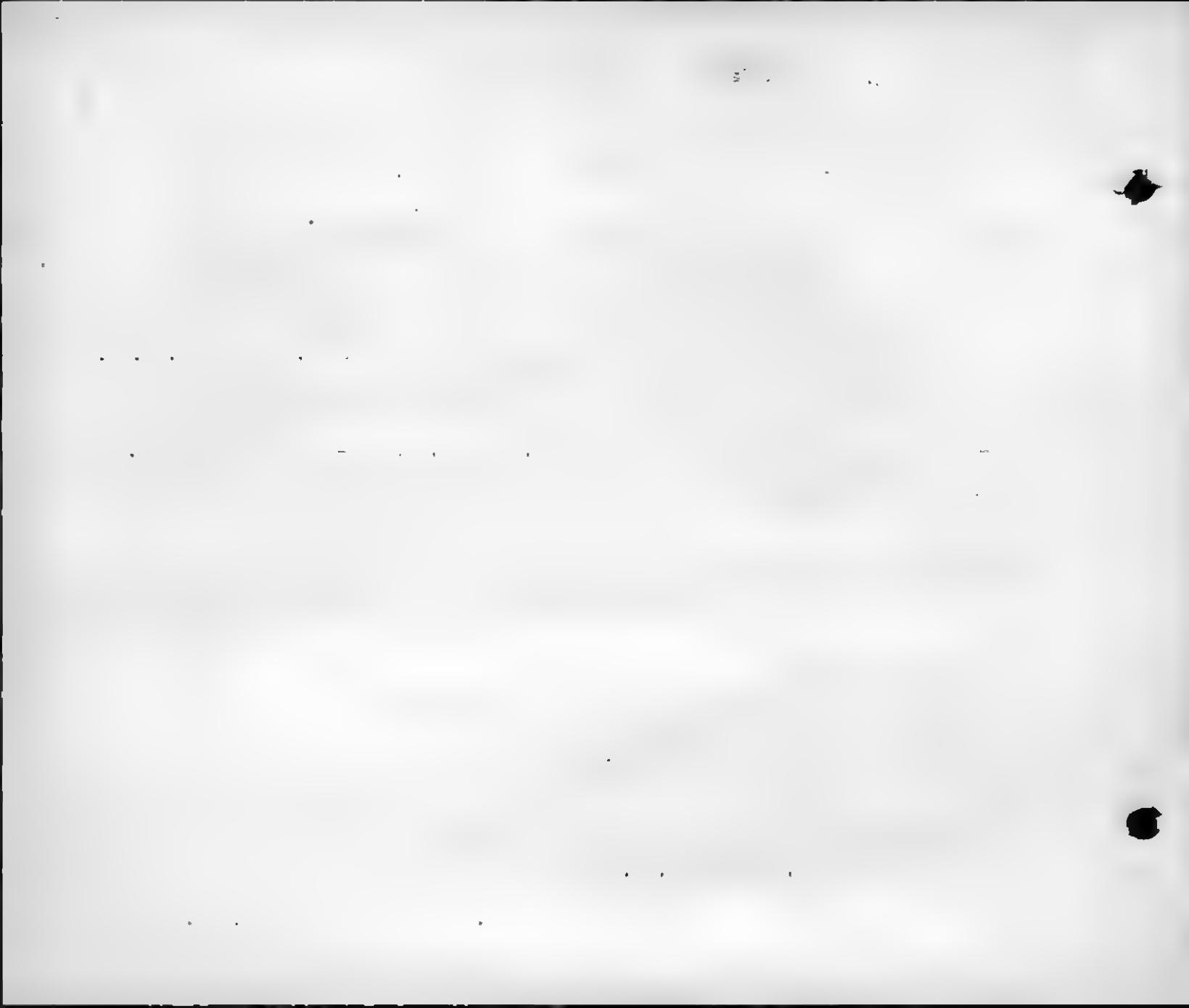
Reg. Dist. No.

12823

| | | | | | | | |
|---|-------------------------------------|---|--|--|---|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland | | b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg | | c. LENGTH OF STAY IN 1b 5 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home | | d. STREET ADDRESS 3116 Grindon Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First Edgar | Middle Adgate | Last Sexsmith | 4. DATE OF DEATH Month NOVEMBER | Day 2 | Year 1959 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 19, 1875 | 9. AGE (in years last birthday) 84 yrs | IF UNDER 1 YEAR Months 84 | IF UNDER 24 HRS Days 0 | Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister | | 10b. KIND OF BUSINESS OR INDUSTRY Methodist Church | | 11. BIRTHPLACE (State or foreign country) Clark County, Mo. | | 12 CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME John Sexsmith | | | | 14. MOTHER'S MAIDEN NAME Mary Boyle Owings | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO ----- | | 17. INFORMANT Mrs. Paul E. Keedy - 3116 Grindon Ave. | | Address | |
| 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) pernicious DUE TO (c) Cerebrovascular accident INTERVAL BETWEEN ONSET AND DEATH 10-31-59 | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) diabetes INTERVAL BETWEEN ONSET AND DEATH 10-21-59 | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month Nov | Day 2 | Year 1959 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) 10128 Cedar Lane | (County) Kensington, Md. |
| 21. I certify that I attended the deceased from Nov 1, 1959 to Nov 2, 1959 that I last saw the deceased alive on Nov 2, 1959 , and that death occurred at 11 P. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Sarah E. Glover | | | | M.D. | | ADDRESS (Street, city or town, state) Kensington, Md. | |
| PHYSICIAN'S NAME (Type) Sarah E. Glover, M. D. | | | | DATE SIGNED 11-2-59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 11/5/59 | 22c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge Cem. | | | 22d. LOCATION (City, town, or county) Pikesville, Md. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John J. Jones - Kalt | | | | ADDRESS 17, Inc. | 24a. REC'D BY REGISTRAR DATE NOV 4 '59 | 24b. REGISTRAR'S SIGNATURE Arthur S. Knob | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

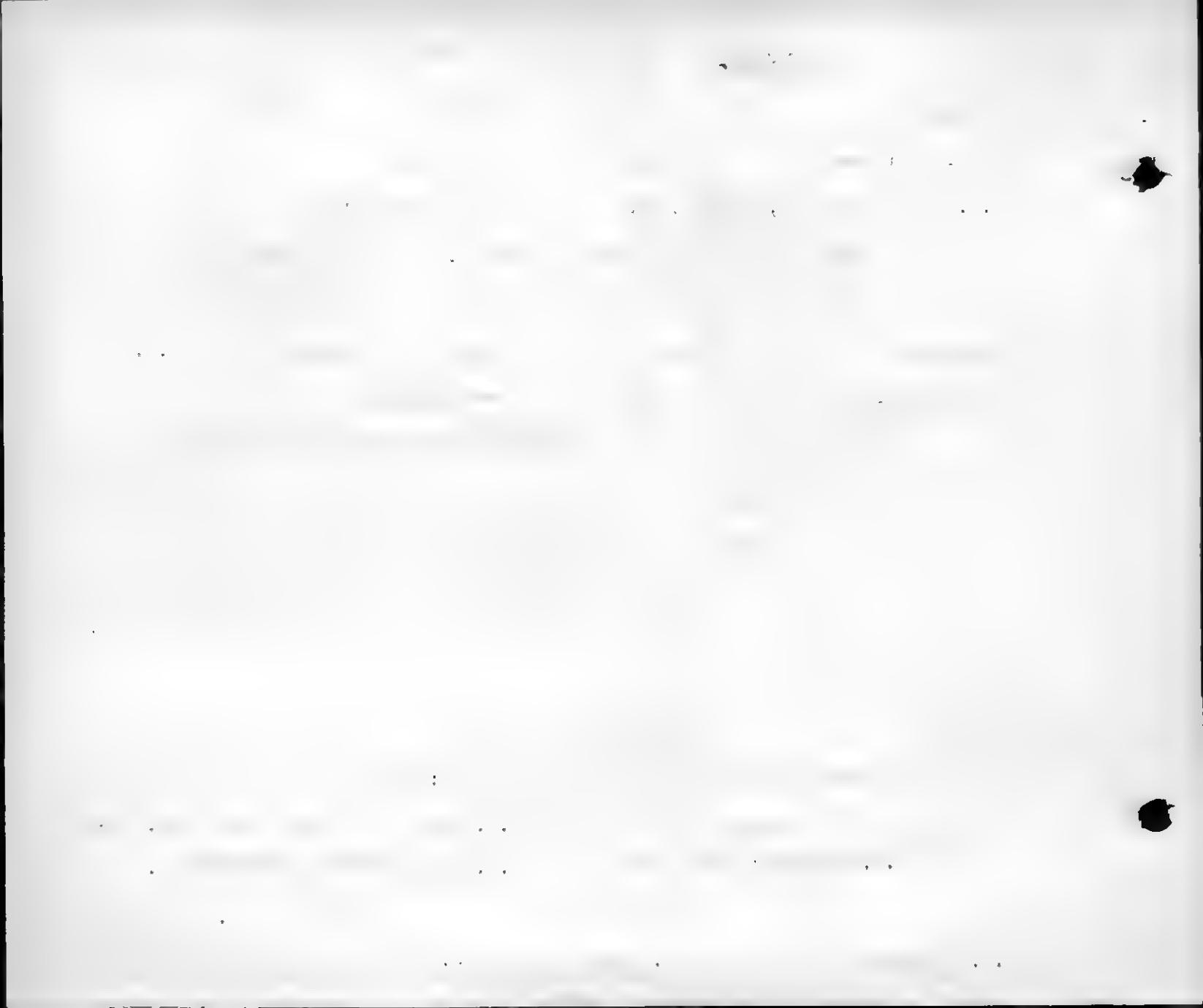
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist No 215

12824

| | | | | | | | |
|---|---|---|--|--|---------------------------------------|---|---------------------|
| 1. PLACE OF DEATH o COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) o STATE Maryland | | b. COUNTY / | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 8 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | d. STREET ADDRESS 12818 Flack Street | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md. | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Mary | Middle Elizabeth | Last SINOPOLI | 4. DATE OF DEATH November 5 1959 | Month November | Day 5 | Year 1959 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-21-05 | 9. AGE (In years last birthday) 54 yrs | IF UNDER 1 YEAR Months 5 | IF UNDER 24 HRS Days 1 | Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) District of Columbia, | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Joseph LOCKE | | | | 14. MOTHER'S MAIDEN NAME Mamie LAMBATH | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO (If yes, give war or dates of service) | INFORMANT (Husband) Jack Sinopoli | Address Same as #2 | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 570.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) PULMONARY CONGESTIVE ATTELECTASIS Due to POST OP COMPLICATION INTESTINAL OBSTRUCTION (c) OBSTRUCTION INTERVAL BETWEEN ONSET AND DEATH 3 DAY S | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) U.S. Naval Hospital, Bethesda Md. | (County) 11-6-59 | (State) MD. | |
| 21. I certify that I attended the deceased from 28 October , 19 59 , to 5 November , 19 59 that I last saw the deceased alive on 5 November , 19 59 , and that death occurred at 10:55 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 11-6-59 | | | | | | | |
| ACTUAL SIGNATURE <i>C.U. Bramlett</i> | PHYSICIAN'S NAME (Type) C.U. BRAMLETT LT MC USN U.S. Naval Hospital, Bethesda Md. | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 11/10/59 | 22c. NAME OF CEMETERY OR CREMATORIUM Arlington National | 22d. LOCATION (City, town, or county) Arlington Va. | (State) VA. | | | |
| 24a. FUNERAL DIRECTOR'S SIGNATURE <i>W.E. Pumphrey</i> | ADDRESS 8434 Georgia Ave. Silver Spring Md. | 24b. REC'D BY REGISTRAR NOV 10 '59 | 24b. REGISTRAR'S SIGNATURE <i>Clinton S. Evans</i> | | | | |



TO HOSPITAL OR PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The hospital or attending physician may be retained by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 & 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | 12896 | | |
|--|--|-------------------------------------|---|---|---|---|--|-------------------------|---|--|--|--|
| Item 21 Film G253 12-14-59 et CERTIFICATE OF DEATH | | | | | | | | | | Reg. Dist. No. | | |
| <i>copy EJ</i> 12825 | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Montgomery | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | | c. LENGTH OF STAY IN 1b 142 days | | | | | b. COUNTY Preston | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newburg, MD | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) JESSIE | | First | Middle | Last | 4. DATE OF DEATH SPANGLER | | Month | Day | Year | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | B. DATE OF BIRTH September 29, 1906 | 9. AGE (In years last birthday) 53 yrs. | | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Days | Hours | Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | | 11. BIRTHPLACE (State or foreign country) West Virginia | | | 12. CITIZEN OF WHAT COUNTRY? U.S. A. | | | |
| 13. FATHER'S NAME Edgar Goff | | | | | 14. MOTHER'S MAIDEN NAME Marcella Dunbar | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | 16. SOCIAL SECURITY NO. None | | | INFORMANT The Clinical Center | | | <small>Address</small> Medical Record | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | | <small>INTERVAL BETWEEN ONSET AND DEATH</small> 1-2 hours | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 420.1 | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic Heart Disease DUE TO | | | | | | | | | | 2 years | | |
| (c) Hypertension, Essential | | | | | | | | | | 4 years | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchial Asthma | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | (State) | | |
| July 11, 1959 | | | 19 | | | | | | | | | |
| 21. I certify that I attended the deceased from <u>July 11, 1959</u> to <u>November 30, 1959</u> , that I last saw the deceased alive on <u>November 30, 1959</u> , and that death occurred at <u>10:30 P.M.</u> ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>Louis Gillespie, Jr.</u> M.D. DATE SIGNED <u>12/1/59</u> | | | | | | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>Louis Gillespie</u> M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 12/2/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM | | | 22d. LOCATION (City, town, or county) NEWBURG, WEST VIRGINIA | | | <small>(State)</small> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Bines Co.</u> | | | | | ADDRESS <u>2901 14th St. N.W. Wash. D.C.</u> | | 24a. REC'D BY REGISTRAR DATE DEC 3 '59 | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

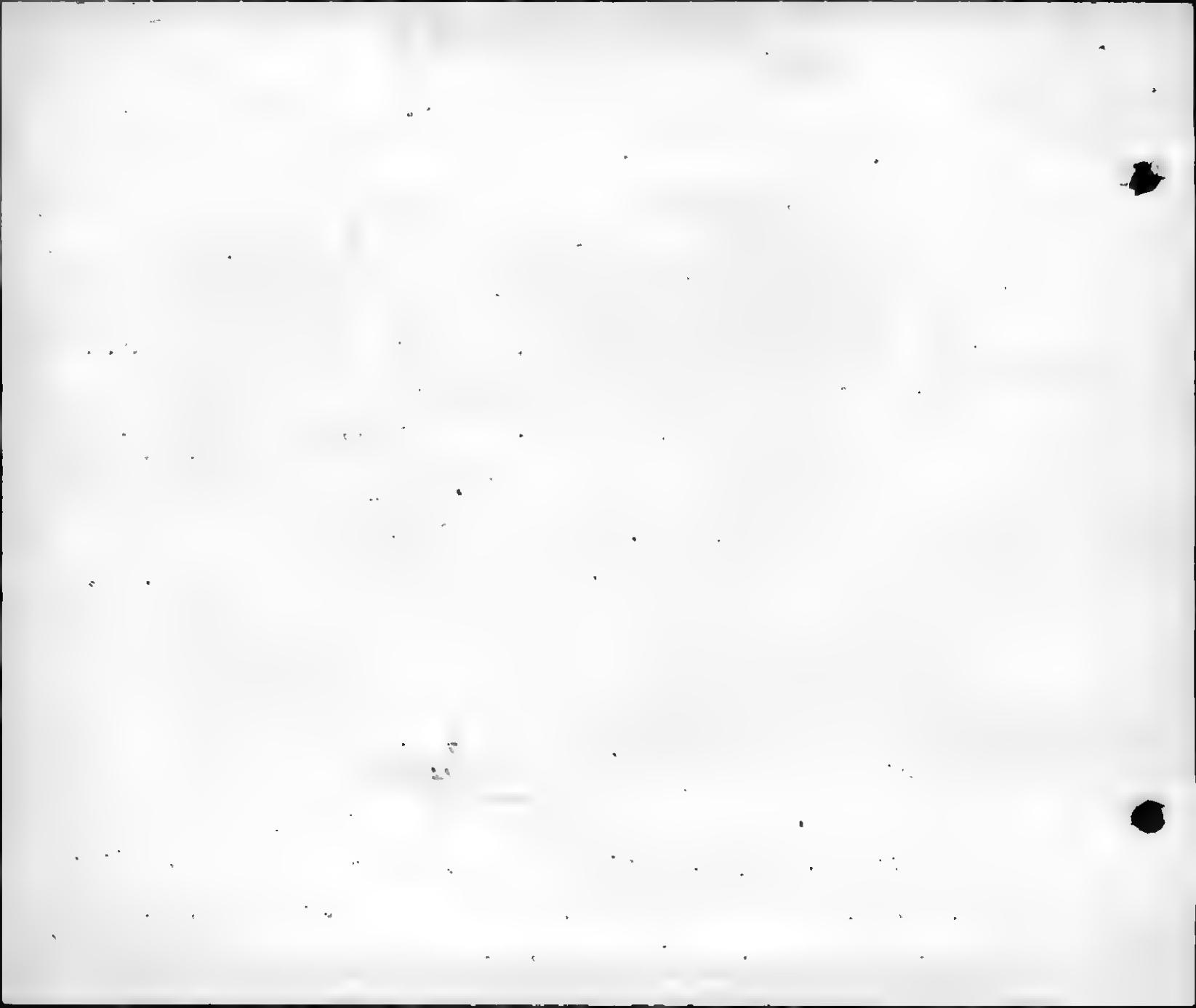
12897

12691

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK | | c. LENGTH OF STAY IN lb 6 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 901 MAPLEWOOD AVENUE | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK | |
| 3. NAME OF DECEASED (Type or print) WARREN | | 4. DATE OF DEATH NOV. 2 1959 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> | 8. DATE OF BIRTH 5/6/80 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist (retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Oil City Water Co. | |
| 10c. BIRTHPLACE (State or foreign country) PENNSYLVANIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME DANIEL SPANGLER | | 14. MOTHER'S MAIDEN NAME ANNA JOHNSTONE | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. NONE | |
| 17. INFORMANT Mrs. Alva Spangler, 901 Maplewood Ave. Takoma Park, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO (c) DUE TO | | <i>Pulmonary Edema</i> <i>1 day</i> <i>Coronary Heart Disease</i> <i>7 yrs</i> <i>Generalized Arteriosclerosis</i> <i>10 yrs</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>June 7, 1959</i> to <i>Nov. 2, 1959</i> that I last saw the deceased alive on <i>Nov 2</i> , 1959, and that death occurred <i>4:30 AM</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>H. B. Orleans</i> | | ADDRESS (Street, city or town, state) <i>4500 Colleerville Rd</i> | |
| PHYSICIAN'S NAME (Type) <i>H. B. ORLEANS</i> | | DATE SIGNED <i>Silver Spring Md</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL | | 22b. DATE THEREOF 11/2/59 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM SUNSET MEM. CEMETERY | | 22d. LOCATION (City, town, or county) (State) VENANGO COUNTY, PA. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. | | 24a. REC'D BY REGISTRAR DATE NOV 3 '59 | |
| Raymond A. Ziska | | 24b. REGISTRAR'S SIGNATURE <i>Calvin S. Krause</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

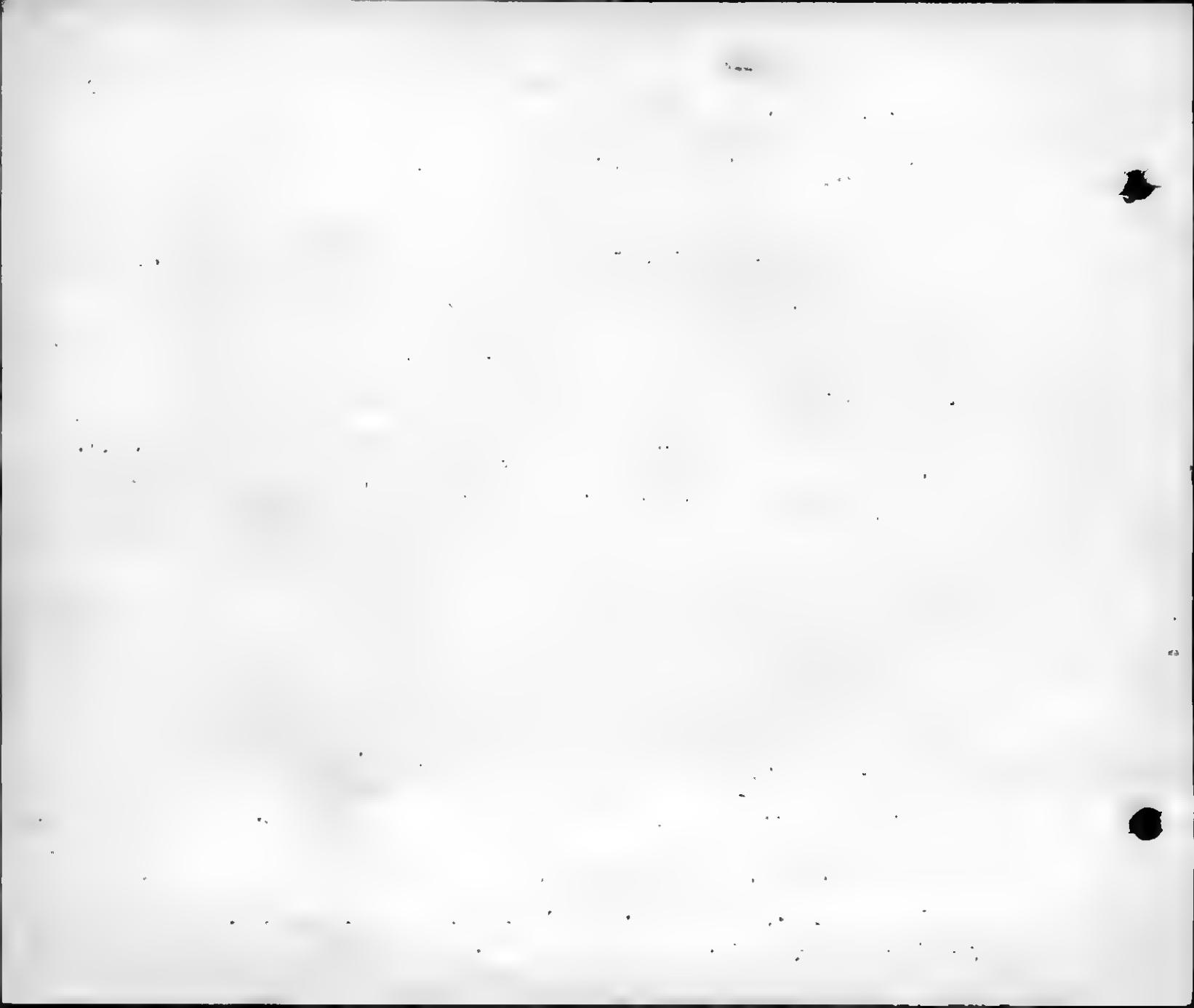
CERTIFICATE OF DEATH

Reg. Dist. No.

12898

12825

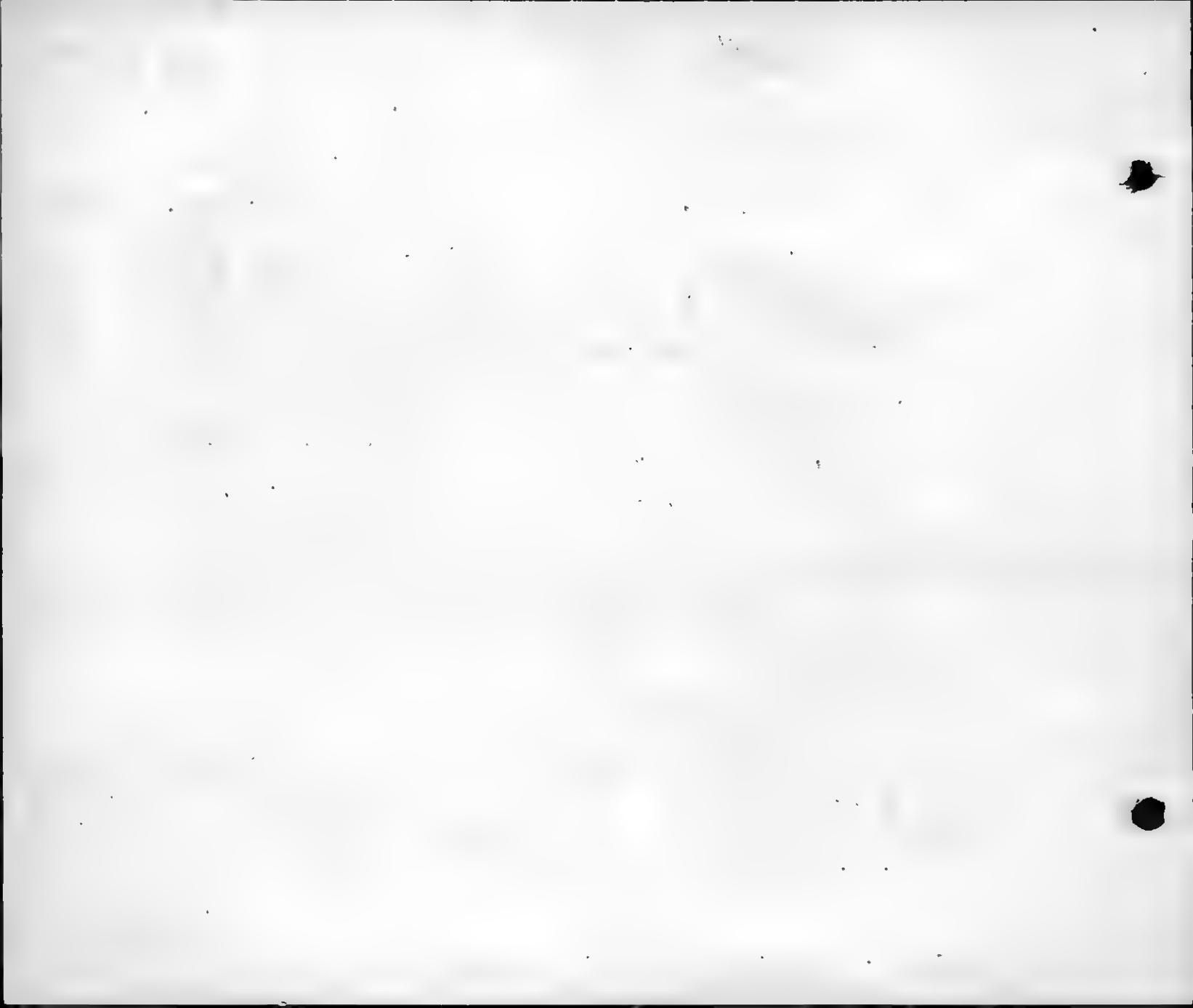
| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| Montgomery MARYLAND | | a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Silver Spring | | c. LENGTH OF STAY IN 1b 4 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 410 Northwest Drive | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Ernst Gustav Heinrich Sprick | | First | Middle |
| | | Last | 4. DATE OF DEATH November 16, 1959 |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |
| | | WIDOWED <input type="checkbox"/> | DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH April 8, 1891 | | 9. AGE (In years lost birthday) 68 yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. US/JAI OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | 11. BIRTHPLACE (State or foreign country) Germany |
| 12. CITIZEN OF WHAT COUNTRY? West Germany | | 13. FATHER'S NAME Albrecht Sprick | |
| 14. MOTHER'S MAIDEN NAME Emelie Siekmann | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | |
| 16. SOCIAL SECURITY NO. None | | INFORMANT Johanna Sprick Silver Spring, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 DUE TO Bronchogenic Carcinoma INTERVAL BETWEEN ONSET AND DEATH 6 months | | Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20c. ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from July 7, 1959, to Nov. 16, 1959, that I last saw the deceased alive on November 16, 1959, and that death occurred at 8:15A, from the causes and on the date stated above. ACTUAL SIGNATURE: <i>Norman H. Rubenstein</i> ADDRESS (Street, city or town, state) DATE SIGNED PHYSICIAN'S NAME (Type) M.D. 6480 New Hampshire Ave. Takoma Park, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Nov. 19, 1959 | 22c. NAME OF CEMETERY OR CREMATORI Sprick Family Cemetery |
| 22d. LOCATION (City, town, or county) Glengary, Va. (State) | | 22e. ADDRESS | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond G. Ziska</i> | | 24a. REC'D BY REGISTRAR DATE NOV 19 '59 | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i> |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | Reg. Dist. No. 12809 | | | | |
|---|--|---|--|---|--|---|--|--|--|--|-----|------|--|--|
| 12827 CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Montgomery | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | | | | b. COUNTY Montgomery | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | | | | c. LENGTH OF STAY IN lb | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10737 Colesville Road | | | | | d. STREET ADDRESS 6800 Connecticut Ave. | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) | | First EUFROSYNE | | Middle | | Last STAMATIS | | 4. DATE OF DEATH November 15 1959 | | Month | Day | Year | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2/2/1870 | | 9. AGE (In years last birthday) 89 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Greece | | 12. CITIZEN OF WHAT COUNTRY? US | | | | | | | | |
| 13. FATHER'S NAME Manual Daskalakis | | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. None | | INFORMANT John Theodore - son-in-law - same ad 2d | | Address | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 194.2 DUE TO <i>Mutastatic CA. Primary pelvis</i> | | | | | | | | | | <i>says.</i> | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | | |
| 21. I certify that I attended the deceased from 11/4 , 19 59 , to 11/13 , 19 59 , that I last saw the deceased alive on 11/12 , 19 59 , and that death occurred at 9:00 P.M. from the causes and on the date stated above. | | | | | | | | | | ADDRESS (Street, city or town, state) 10114 Colasville Rd. Silver Spring, Md. | | | | |
| ACTUAL SIGNATURE <i>A. F. Thibadeau</i> | | DATE SIGNED 11/16/59 | | | | | | | | | | | | |
| PHYSICIAN'S NAME (Type) A. F. Thibadeau | | M.D. | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/18/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery | | 22d. LOCATION (City, town, or county) Rockville, Maryland | | (State) | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Maryland | | 24a. REC'D BY REGISTRAR NOV 18 '59 | | 24b. REGISTRAR'S SIGNATURE <i>Charles S. Knudsen</i> | | | | | | | | |
| VS A15 (4) 15M 9/58 | | | | | | | | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12828

CERTIFICATE OF DEATH

Reg. Dist. No.

12810

| | | | | | | |
|---|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE SAME - MD. b. COUNTY MONTGOMERY | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10105 MCKENNEY AVE. | d. STREET ADDRESS 10105 - MCKENNEY AVE. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) LEO | First | Middle | Last | | | |
| | | NONE | STERN | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JULY 10 1879 | 9. AGE (in years last birthday) 80 yrs | 10. IF UNDER 1 YEAR Months 9 Days 1 Hours 0 Min. | 11. IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT | | 10b. KIND OF BUSINESS OR INDUSTRY CLOTHING | | 11. BIRTHPLACE (State or foreign country) GERMANY | | 12. CITIZEN OF WHAT COUNTRY USA |
| 13. FATHER'S NAME ISAAC STERN | | 14. MOTHER'S MAIDEN NAME CAROLINE ROTHSCHILD | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ND | | 16. SOCIAL SECURITY NO. UNKNOWN | | 17. INFORMANT HELEN STERN Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO 420.1 CORONARY THROMBOSIS | | | | | | INTERVAL BETWEEN ONSET AND DEATH SUDDEN |
| Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO ARTERIO SCLEROSIS | | | | | | 8 YRS |
| (c) | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NONE | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from MAY 1959, to NOV 11, 1959, that I last saw the deceased alive on NOV 9, 1959, and that death occurred at 8 AM, from the causes and on the date stated above. ACTUAL SIGNATURE Henry W. Stout, M.D. ADDRESS (Street, city or town, state) 10211 GEORGIA AVE. DATE SIGNED 11/11/59 | | | | | | |
| PHYSICIAN'S NAME (Type) HENRY W. STOUT | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 11-12-59 | | 22c. NAME OF CEMETERY OR Crematory Mt. Lebanon Cemetery | | 22d. LOCATION (City, town, or county) HYATTSVILLE MD (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY & SONS - 3501-1413 ST NW | | ADDRESS | | 24a. REC'D BY REGISTRAR NOV 13 '59 DATE | | 24b. REGISTRAR'S SIGNATURE Charles S. Krause |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12811

Reg. Dist. No.

DEPUTY [REDACTED] This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.

| | | | | | | | |
|---|--|---|---|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | | |
| Montgomery County, Maryland | | | a. STATE Maryland b. COUNTY Montgomery | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b D.O.A. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chevy Chase | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban | | | d. STREET ADDRESS 3911 Aspen St. | | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First Nellie | Middle Ann | Last Stouffer | 4. DATE OF DEATH Month Nov. Day 21 Year 1951 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 2, 1883 | | 9. AGE (in years last birthday) 76 yrs. | IF UNDER 1YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Voice Teacher | | 10b. KIND OF BUSINESS OR INDUSTRY Teaching | 11. BIRTHPLACE (State or foreign country) Canton, Ill | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Terah Smith | | | 14. MOTHER'S MAIDEN NAME Alice Dancer | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. 223-30-4325 | 17. INFORMANT Daughter Mrs. A. Thurston | | Address 516 W. Above | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which give rise to immediate cause (b) (a), stating the underlying cause last. (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH suicide | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED 11-24-59 | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 11/27/59 | 22b. DATE THEREOF 11/27/59 | 22c. NAME OF CEMETERY OR CREMATORIAL Greenwood Cemetery | 22d. LOCATION (City, town, or county) Canton, Illinois | | (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland | | | ADDRESS | 24a. REC'D BY REGISTRAR NOV 27 '59 | 24b. REGISTRAR'S SIGNATURE Oscar S. Kraus | | |



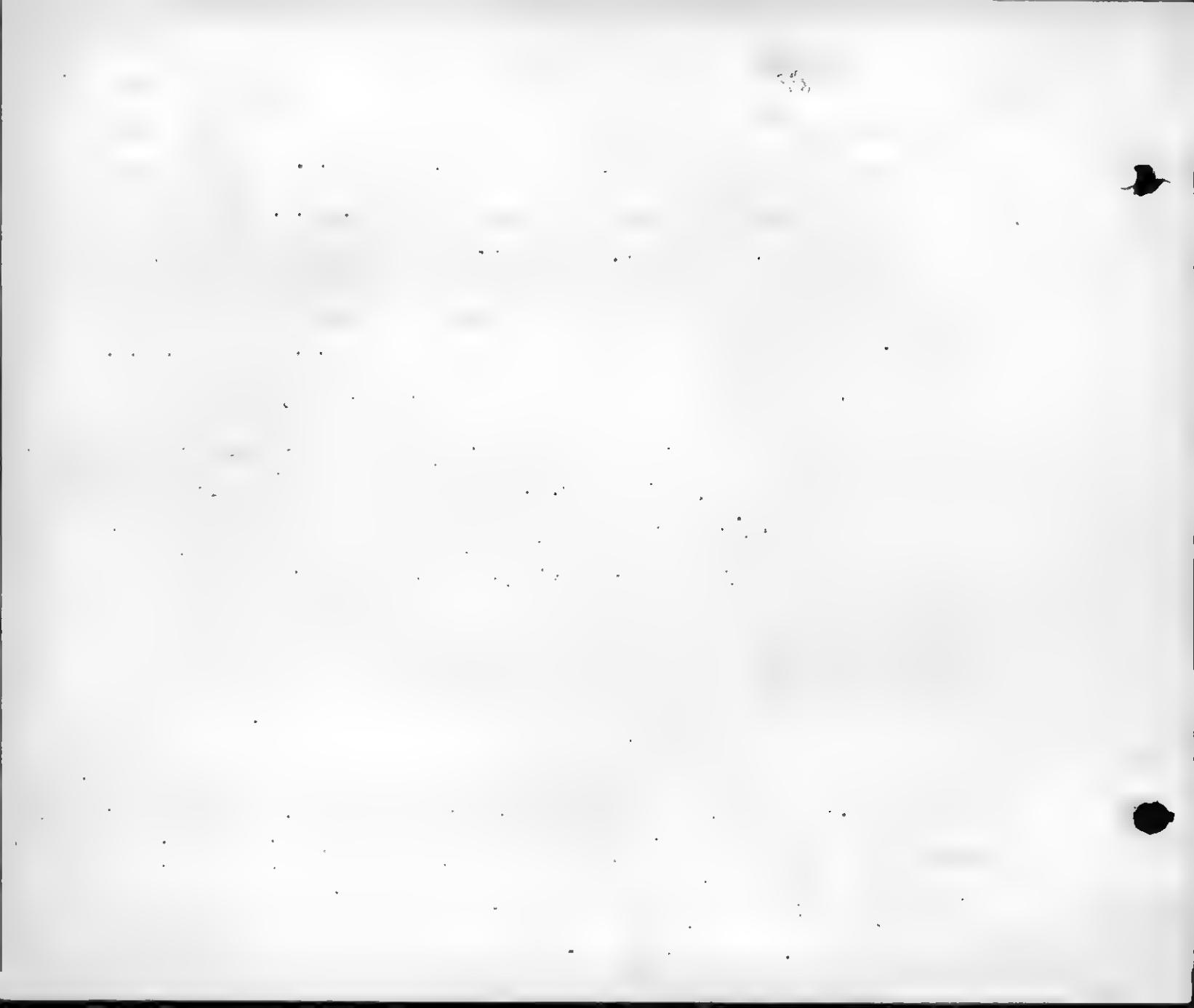
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12812

CERTIFICATE OF DEATH

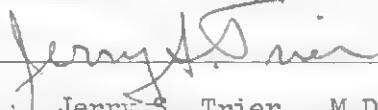
Reg. Dist. No.

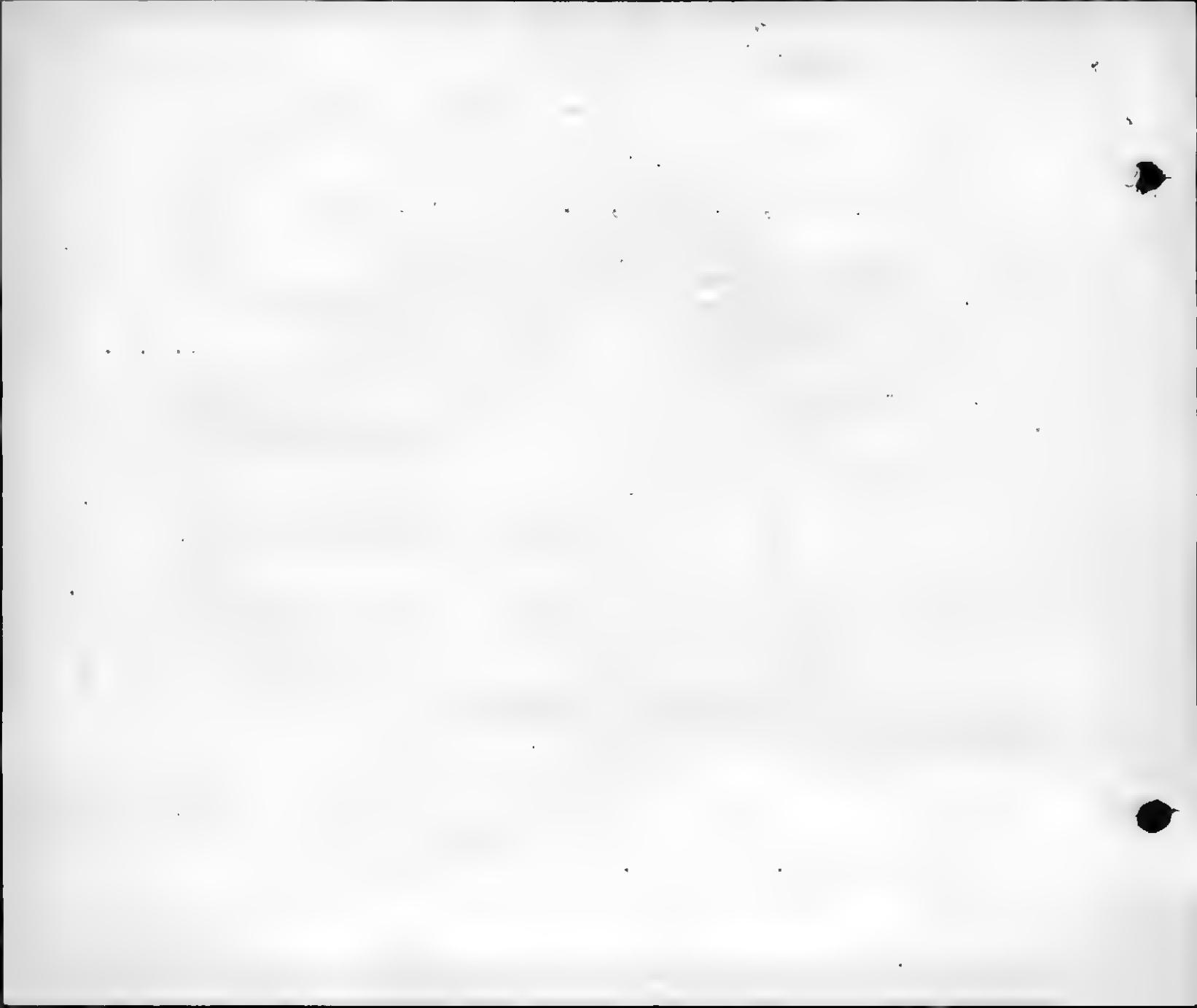
| | | | | | | | | | | | |
|---|--|---|---|--|--|---|-------------------------------------|---------------------------------|-----------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery County | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | | ✓ | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 11 hours | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital | | | | d. STREET ADDRESS 45 New York Ave., N.W. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First Evelyn | Middle A. | Last Stuart | 4. DATE OF DEATH November 21 | Month November | Day 21 | Year 1959 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/11/13 | 9. AGE (In years lost birthday) 46 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS Days 0 | Hours 0 | Min 0 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Avon Representative | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Washington D.C. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | |
| 13. FATHER'S NAME Edmund W. Lingebach | | 14. MOTHER'S MAIDEN NAME Rose M einberg | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO Yes | | INFORMANT Hilda M. Raedy | | Address 9003 Wellington St.; Sebrook, Md. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) POX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last DUE TO (b) Hypertensive vascular disease and probably II live. (c) Congenital cerebral aneurysm. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH sister | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Colman Manor | | (County) Colman Manor | (State) Md. | | |
| 21. I certify that I attended the deceased from 11-20-1959 to 11-21-1959 , that I last saw the deceased alive on 11-21-1959 , and that death occurred at 7:30 a.m. from the causes and on the date stated above. | | | | | | | | | | ADDRESS (Street, city or town, state) 4422 East West Hwy., -11/21/59. | DATE SIGNED George L. Gray, Jr. M.D. -11/21/59. |
| ACTUAL SIGNATURE George L. Gray, Jr. M.D. | | PHYSICIAN'S NAME (Type) Geo. L. GRAY, JR. M.D. Bethesda 14, Md. | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/24/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Mr. Lincoln | | 22d. LOCATION (City, town, or county) Colman Manor | | (State) Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Timothy Haubner | | ADDRESS 3831 Galax Way | | 24a. REC'D BY REGISTRAR DEC 2 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Krause | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | Reg. Dist. No. 12813 | | |
|--|--|-------------------------------------|---|--|--|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. PLACE OF DEATH <input checked="" type="checkbox"/> COUNTY Montgomery | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) <input checked="" type="checkbox"/> STATE West Virginia | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | | c. LENGTH OF STAY IN 1b 21 days | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Petersburg | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | | d. STREET ADDRESS No Street Address | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | | First John | Middle Richard | Last Stump | 4. DATE OF DEATH November 29 1959 | | Month November | Day 29 | Year 1959 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | 8. DATE OF BIRTH October 26, 1954 | | 9. AGE (In years last birthday) 5 yrs. | | IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME Elwood Grant Stump | | | | | 14. MOTHER'S MAIDEN NAME Mayselle J. Riggelman | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? <small>(Lat. no. or unknown)</small> No | | | 16. SOCIAL SECURITY NO. <small>(If yes, give war or dates of service)</small> None | | | INFORMANT The Medical Record <small>Address</small> The Clinical Center, Bethesda 14, Maryland | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 min. | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration | | | | | | | | | | | | |
| DUE TO <small>104.5</small> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last | | | | | | | | | | (b) Upper Respiratory & Gastro Intestinal Bleeding 10 days | | |
| DUE TO <small>(c)</small> Acute Lymphatic Leukemia | | | | | | | | | | 9 mon. | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>(IF EITHER, NOTIFY MEDICAL EXAMINER)</small> | | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) <small>(County)</small> | | <small>(State)</small> | | | |
| 21. I certify that I attended the deceased from November 8, 1959, to November 29, 1959 that I last saw the deceased alive on November 29, 1959, and that death occurred at 12:15 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 11/29/59 | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | | | | | | | M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland | | |
| PHYSICIAN'S NAME (Type) Jerry S. Trier M.D. | | | | | | | | | | | | |
| 22d. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12/2/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Tahmansville Cemetery | | | 22d. LOCATION (City, town, or county) <small>(State)</small> Thamansville, W. Virginia | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland | | | | | | | | | | 24a. REC'D BY REGISTRAR DATE DEC 2 '59 | | |
| | | | | | | | | | | 24b. REGISTRAR'S SIGNATURE  | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G272 11/20/59 J.K.

12814

12832

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY County MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | c. LENGTH OF STAY IN lb 18 MOS. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Holmes Woodland Sdn. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First MARY | Middle KING | Last SUMNER |
| 4. DATE OF DEATH | Month NOV. | Day 5 | Year 1959 |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 15, 1875 |
| 9. AGE (in years last birthday) 84 yrs. | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COMM. ARTIST | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't. | 11. BIRTHPLACE (State or foreign country) MICHIGAN |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | 13. FATHER'S NAME John Holmes STONE | | |
| 14. MOTHER'S MAIDEN NAME SUSAN M. KING | INFORMANT NURSING Home RECORDS | | |
| Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) | | | |
| Pulmonary edema INTERVAL BETWEEN ONSET AND DEATH 72 hrs Arteriosclerotic Heart Disease st. 10 yrs. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(c) Cerebral Vascular Accident (Thromboses) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 19 | | | |
| 21. I certify that I attended the deceased from Aug. , 1959, to November 1959 , that I last saw the deceased alive on Sept. 4 , 1959, and that death occurred at 4 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Ralph E. Patten</i> | M.D. | ADDRESS (Street, city or town, state) 864 Colesville Road | DATE SIGNED 11/4/59 |
| PHYSICIAN'S NAME (Type) Ralph E. Patten M.D. | | | |
| 22a. BURIAL, CREMATION, CREMATION | 22b. DATE THEREOF 11/6/59 | 22c. NAME OF CEMETERY OR CREMATORIUM CEDAR HILL CEMETORY | 22d. LOCATION (City, town, or county) SUITLAND, MD. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gantner Son | ADDRESS 1756 PA. AVE., N.W. DC | 24a. REC'D BY REGISTRAR DATE NOV 9 '59 | 24b. REGISTRAR'S SIGNATURE Arthur S. Krause |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12815

12833 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | |
|--|--|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Ohio | | b. COUNTY |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 7 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wooster | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | d. STREET ADDRESS 345½ East Henry Street | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

| | | | | | | |
|--|-------------------------|----------------------|-----------------------|--|------------------|---------------------|
| 3. NAME OF DECEASED (Type or print) | First DOROTHY | Middle MAE | Last TAYLOR | 4. DATE OF DEATH Month November | Day 3, | Year 1959 |
|--|-------------------------|----------------------|-----------------------|--|------------------|---------------------|

| | | | | | | | |
|-------------------------|----------------------------------|---|---|---|---------------------------------------|--------------------------------------|------------------|
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH April 16, 1941 | 9. AGE (In years last birthday) 18 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS Hours 0 | Min. 0 |
|-------------------------|----------------------------------|---|---|---|---------------------------------------|--------------------------------------|------------------|

| | | | |
|--|-----------------------------------|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Ohio | 12. CITIZEN OF WHAT COUNTRY U. S. A. |
|--|-----------------------------------|--|--|

| | | |
|---|---|---|
| 13. FATHER'S NAME Paul Taylor | 14. MOTHER'S MAIDEN NAME Ieta Weber | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) No | 16. SOCIAL SECURITY NO unavailable | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Md. |

| | | |
|---|--|----------------------------------|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebellar hemorrhage | | 5 days |
| DUE TO 173X | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Metastatic Choriocarcinoma | | |
| DUE TO (c) | | 5 months |

| | | |
|--|--|---|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |

| | | |
|---|---|---|
| 20c. TIME OF INJURY Hour o. m. p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
|---|---|---|

21. I certify that I attended the deceased from **October 27, 1959**, to **November 3, 1959**, that I last saw the deceased alive on **November 3, 1959**, and that death occurred at **7:45 P.M.**, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

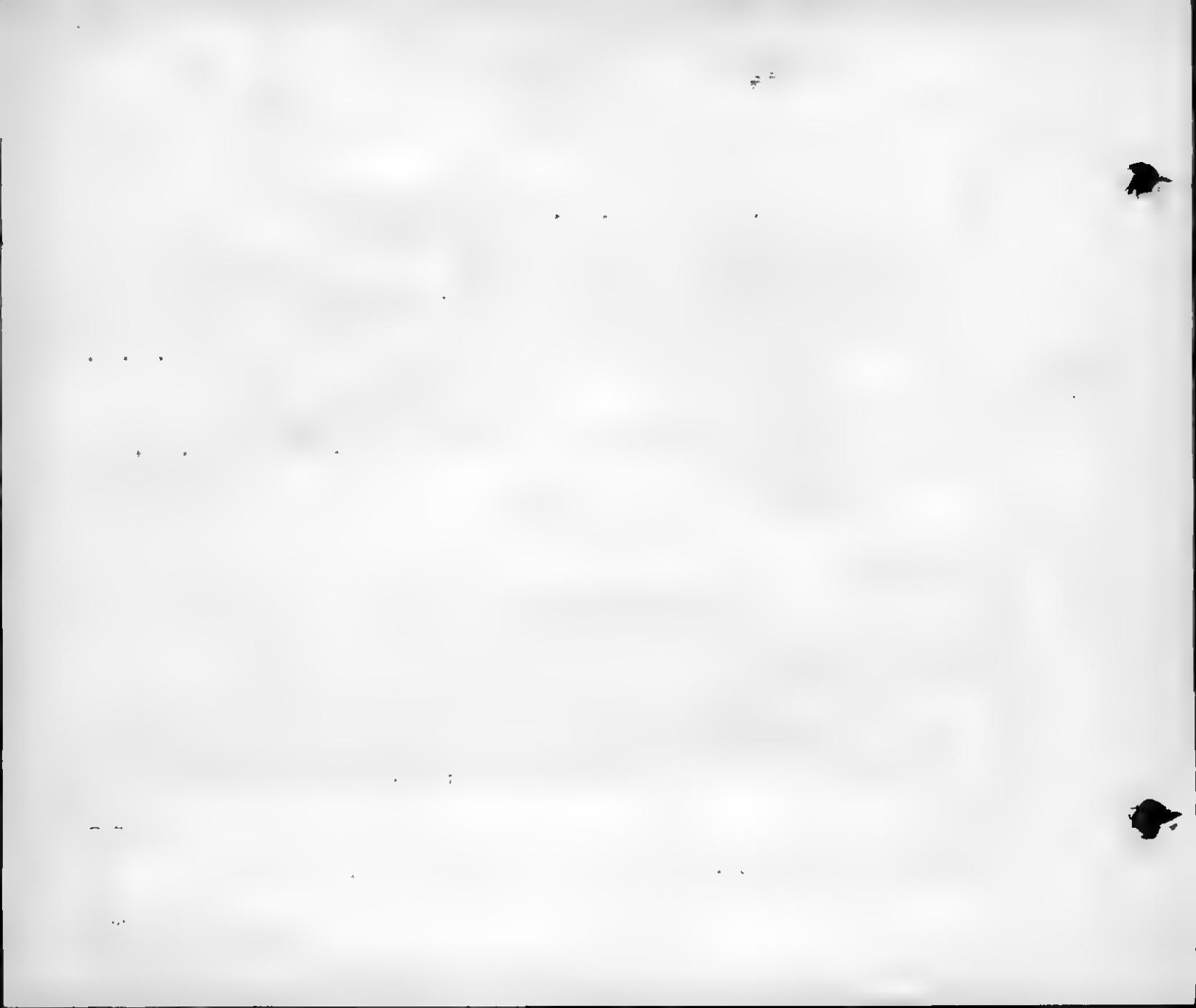
DATE SIGNED

ACTUAL SIGNATURE Saul Genuth M.D. **11-4-59**

POLICE SIGNATURE National Institutes of Health
PHYSICIAN'S NAME (Type) **Saul Genuth, M.D.**

22b. BURIAL, CREMATION, REMOVAL (Specify) **SHIPPER** 22c. DATE THEREOF **11-5-59** 22d. LOCATION (City, town, or county) **WOOSTER OHIO** (State)

23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers ADDRESS **1400 Chapin St N** 24a. REC'D BY REGISTRAR **NOV 5 '59** 24b. REGISTRAR'S SIGNATURE Charles S. Haas

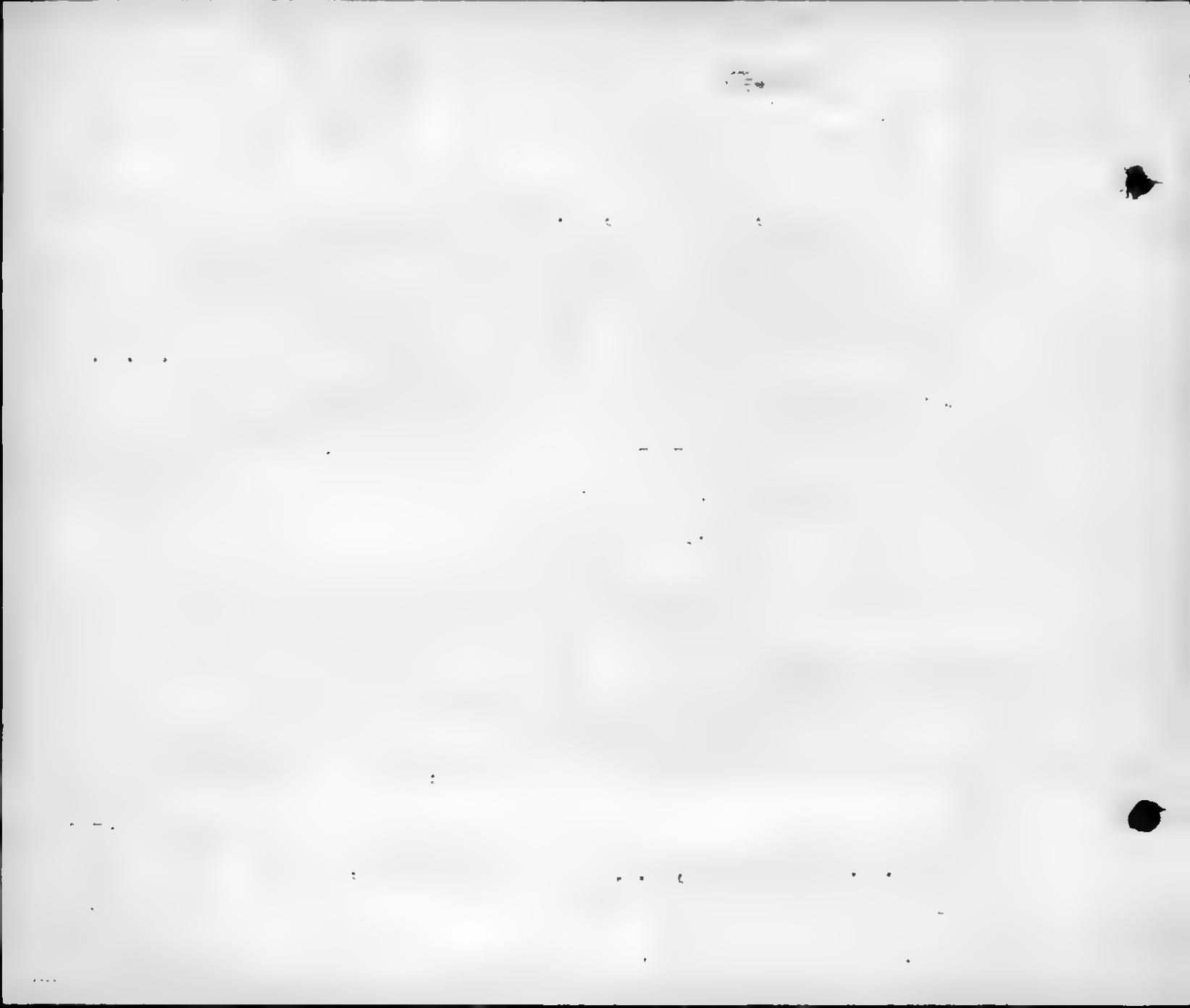


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

12816

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---|
| 1 PLACE OF DEATH a. COUNTY Montgomery | | 2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE New Jersey | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c LENGTH OF STAY IN 1b 9 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | e. STREET ADDRESS 1291 Cedar Avenue | |
| 3 NAME OF DECEASED (Type or print) RUBY SUSAN THIES | | 4. DATE OF DEATH November 3, 1959 | Month Day Year |
| 5 SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH June 7, 1916 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY none | 11. BIRTHPLACE (State or foreign country) Illinois |
| 12. CITIZEN OF WHAT COUNTRY U. S. A. | | 13. FATHER'S NAME William Koingsfeld | |
| 14. MOTHER'S MAIDEN NAME Sophia Berg | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | |
| 16. SOCIAL SECURITY NO. 320-01-5367 | | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Encephalomalacia 754.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. Artrial Septal Defect DUE TO (b) Life (c) | | INTERVAL BETWEEN ONSET AND DEATH 4 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from October 25, 1959 to November 3, 1959 , that I last saw the deceased alive on November 3, 1959 , and that death occurred at 10:45 P.M. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland | |
| ACTUAL SIGNATURE E.C. Brockenbrough, M.D. | | DATE SIGNED 11-4-59 | |
| PHYSICIAN'S NAME (Type) E. C. Brockenbrough, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Bury-Trans | | 22b. DATE THEREOF 11/5/1959 | 22c. NAME OF CEMETERY OR CREMATORIUM Hillside |
| 22d. LOCATION (City, town, or county) Plainfield | | (State) New Jersey | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland | | 24a. REC'D. BY REGISTRAR DATE NOV 6 '59 | 24b. REGISTRAR'S SIGNATURE Arthur S. Thorne |



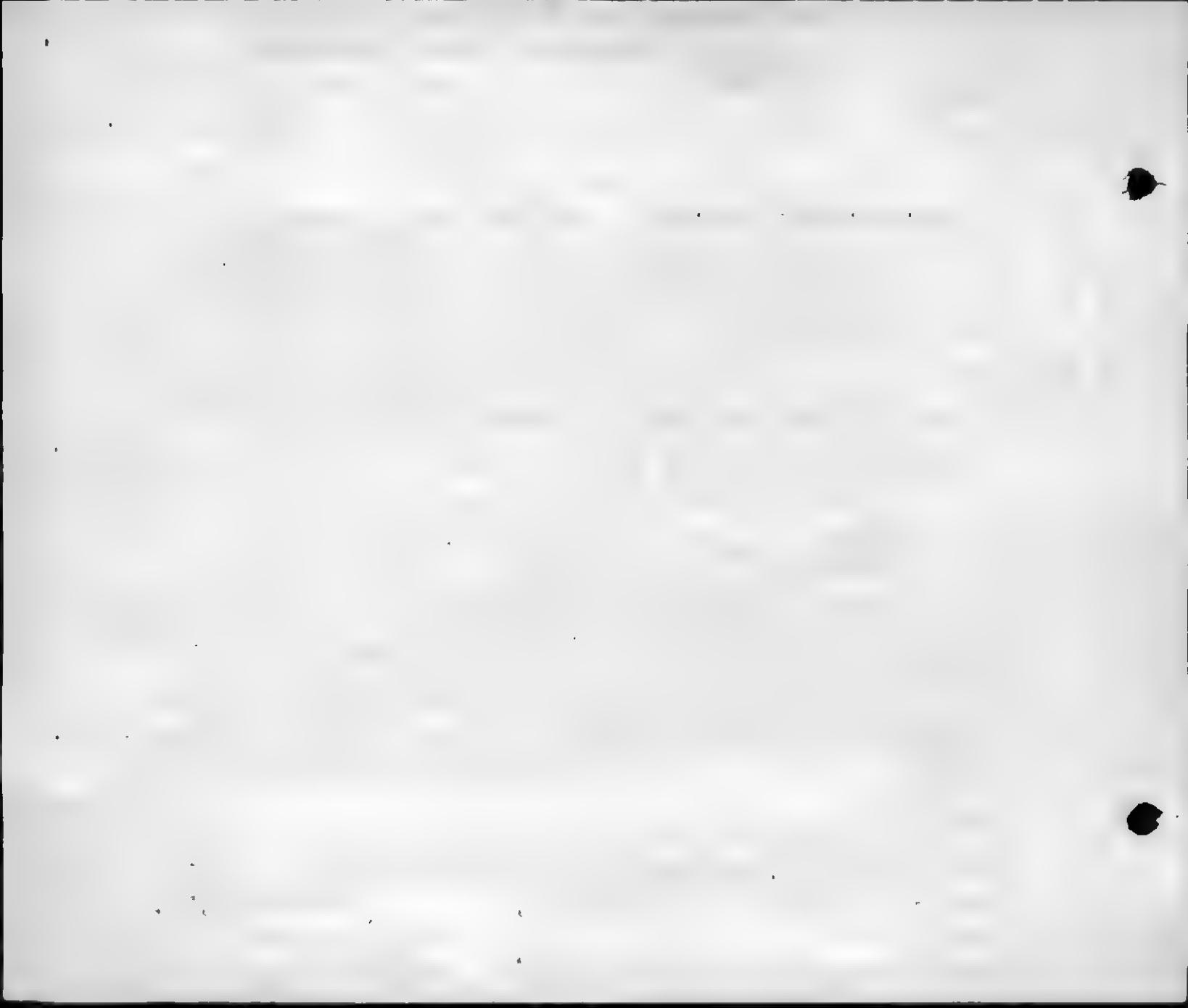
12817

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

| | | | | | | | | | |
|---|--|--|---|---|--|---|----------------------------------|-----------------|-------------|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | | | |
| 12835 Montgomery MARYLAND | | | | b. STATE Maryland b. COUNTY Montg. | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring | | d. STREET ADDRESS | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montg. Co. Gen. Hosp. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First John | Middle Robert | Last Thomas | 4. DATE OF DEATH | Month Nov. 14 | Day 19 | Year 59 | |
| 5. SEX male | | 6. COLOR OR RACE col | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 11/26/33 | 9. AGE (In years last birthday) 25 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | |
| 13. FATHER'S NAME George Thomas | | | 14. MOTHER'S MAIDEN NAME Caroline Awkward | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO. | | | 17. INFORMANT Caroline Thomas, Sandy Spring, Md. | | | |
| Address | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal Hemorrhage | | | | | | | | | |
| 3235 DUE TO (b) Rupture of liver & Rt. Kidney | | | | | | | | | |
| DUE TO (c) Auto accident | | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| Compound fractures of rt. arm & forearm | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto involved in accident | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 7:53 AM 11/14 1959 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway | | 20f. (City or town) Braddockville | | (County) Montg. | (State) Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i> | | | | | | | | | |
| M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | |
| DATE SIGNED 11/15/59 | | | | | | | | | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | |
| 22b. DATE THEREOF 11/18/59 | | 22c. NAME OF CEMETERY OR CREMATORIAL Ash Memorial, | | | | | | | |
| 22d. LOCATION (City, town, or county) Sandy Spring, Md. | | (State) | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snodden</i> | | ADDRESS Rockville, Md. | | 24a. REC'D BY REGISTRAR DATE NOV 19 '59 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Khan</i> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

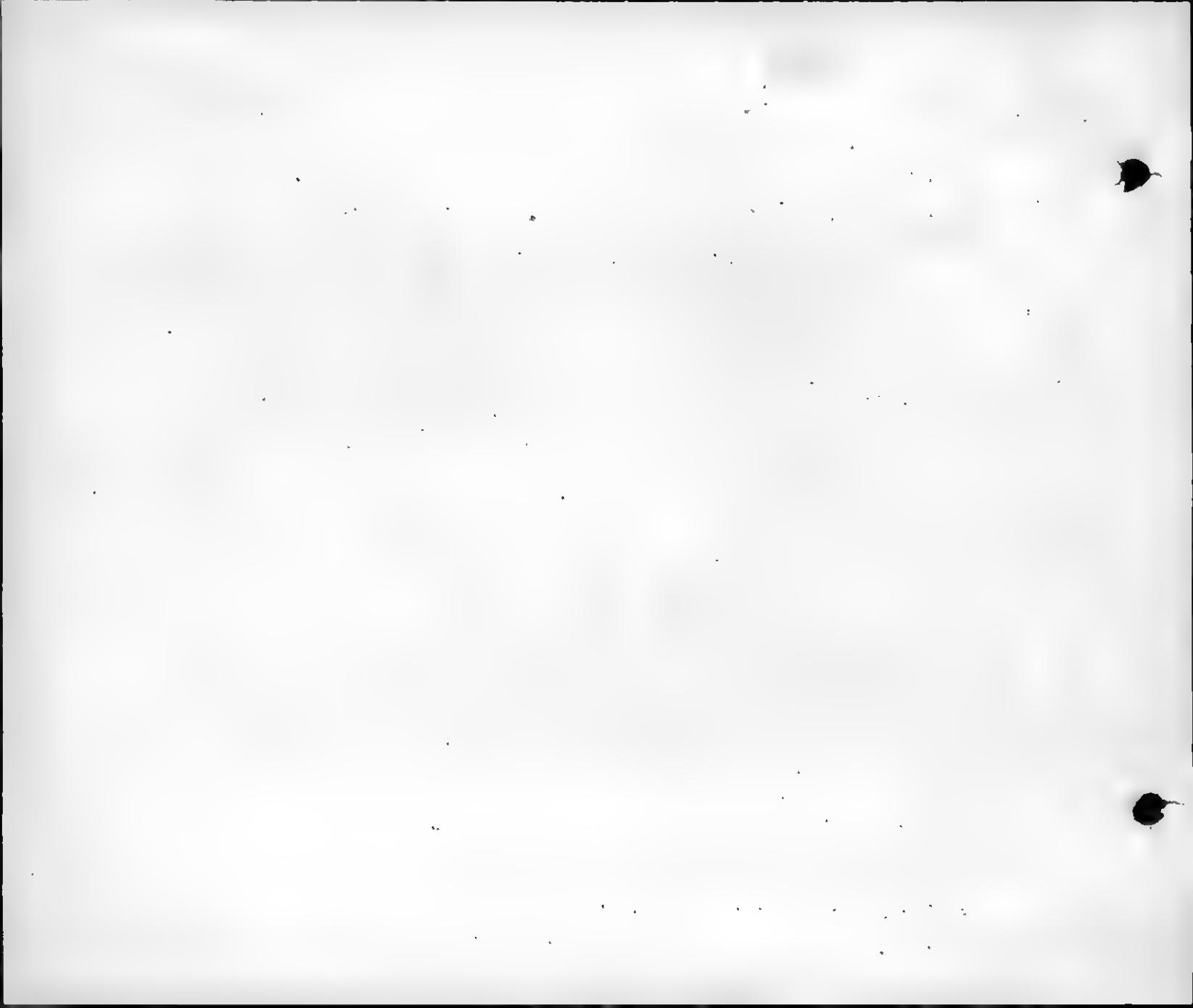
12692

CERTIFICATE OF DEATH

Reg. Dist. No.

12818

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) | |
| <i>Montgomery</i> | | a. STATE | b. COUNTY |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| <i>Takoma Park</i> | | <i>Silver Spring</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| <i>Washington Sanitorium & Hosp. 605 Sisson St</i> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle |
| <i>Mr. A BRAM (NHN)</i> | | <i>Thorner</i> | 4. DATE OF DEATH |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |
| <i>Male</i> | | <i>White</i> | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | 10. IF UNDER 1 YEAR IF UNDER 24 HRS |
| <i>12-25-86</i> | | <i>72 yrs.</i> | Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| <i>Dress Designer</i> | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY? | | | |
| <i>American</i> | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| <i>Herman Thorner</i> | | <i>Yetta Bock</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| <i>No</i> | | <i>UNKNOWN</i> | |
| 17. INFORMANT | | Address | |
| <i>Robert Thorner - 605 Sisson St.</i> | | <i>S.S. Edema 8 Hours</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | 8 Hours | |
| 420.0 DUE TO Congestive Heart Failure with Pulmonary Edema | | 8 Hours | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. | | DUE TO Myocardial Infarction 8 Hours | |
| (b) DUE TO | | Arteriosclerotic Heart Disease 5 Years | |
| (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July, 1959, to 11/24, 1959, that I last saw the deceased alive on 11/24 4:10 PM, 1959, and that death occurred at 5:45 PM, from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) | |
| ACTUAL SIGNATURE <i>Stuart L. Nelson</i> | | DATE SIGNED | |
| PHYSICIAN'S NAME (Type) <i>STUART L. NELSON</i> | | M.D. 7500 Carroll Avenue, Takoma Park, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 22b. DATE THEREOF <i>NOV. 27, 1959</i> | |
| 22c. NAME OF CEMETERY OR CREMATORIUM <i>OLD MT. CARMEL CEMETERY</i> | | 22d. LOCATION (City, town, or county) <i>QUEENS</i> (State) <i>N.Y.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>B. DANZANSKY & SONS</i> | | ADDRESS <i>3501-14th St NW</i> | |
| 24a. REC'D BY REGISTRAR DATE <i>NOV 27 '59</i> | | 24b. REGISTRAR'S SIGNATURE <i>Calvin S. Knoll</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12836

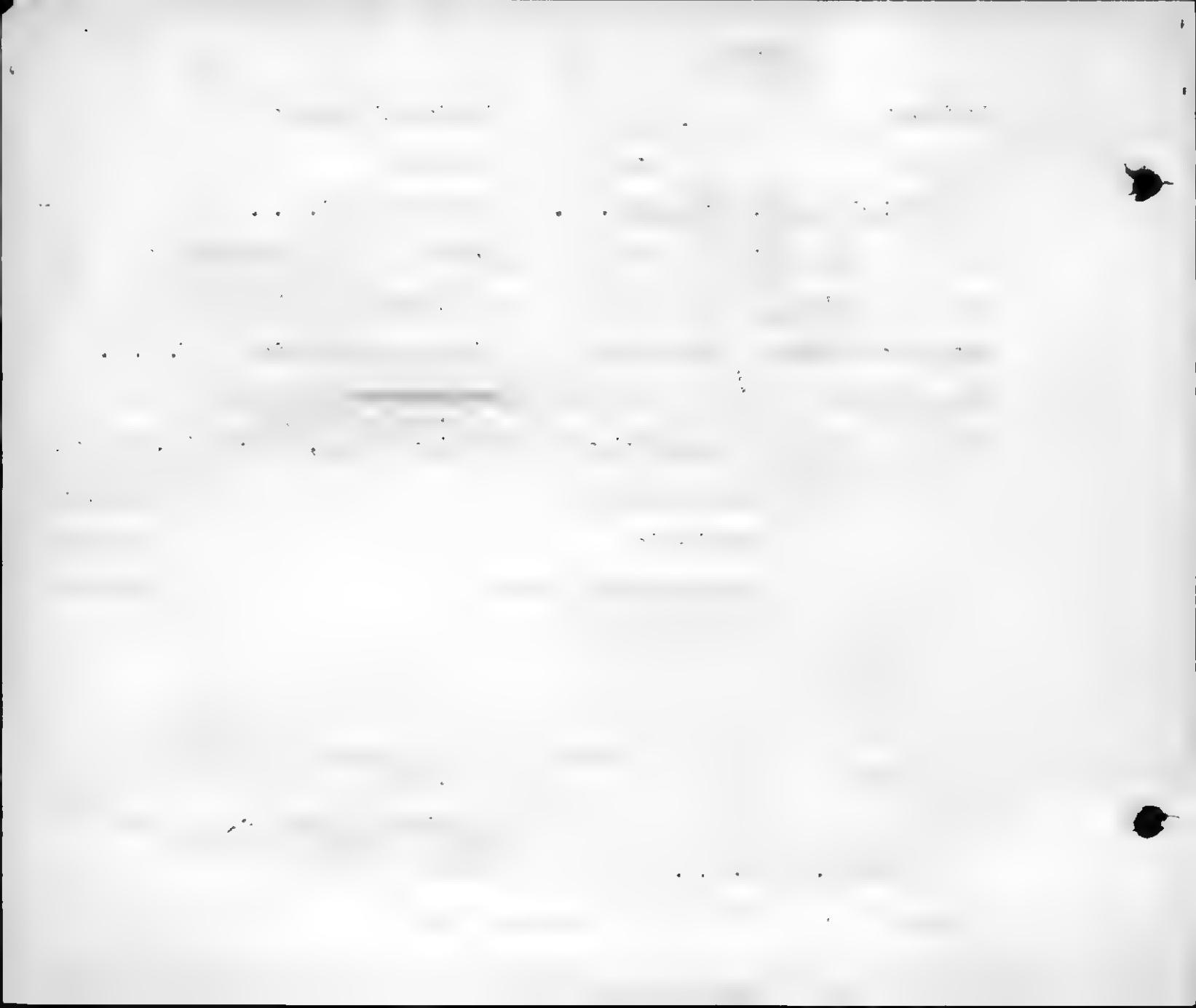
CERTIFICATE OF DEATH

Reg. Dist. No.

12813

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate ■ executed within 24 hours ■ may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | |
|---|----------------------------------|---|----------------------------------|--|--|--|---------------------------|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia | | b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN TB 7 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | d. STREET ADDRESS 2420 16th Street, N.W. | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | | | | | |
| 3. NAME OF (Type or print) Louis | | First | Middle | Last | 4. DATE OF DEATH November 2 | Month | Day | Year 1959 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> | DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 20, 1898 | 9. AGE (In years last birthday) 61 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Days Hours Min |
| 10a. US LAB OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Broker | | 10b. KIND OF BUSINESS OR INDUSTRY Real Estate | | 11. BIRTHPLACE (State or foreign country) District of Columbia | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | |
| 13. FATHER'S NAME Harry Towbes | | 14. MOTHER'S MAIDEN NAME Golda Levy | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. WVI Unascertainable | | INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lebar pneumonia DUE TO (b) Septicemia DUE TO (c) Acute Myelocytic Leukemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 24 hours | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 24 hours | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 31 years | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from October 26, 1959 , to November 2, 1959 , that I last saw the deceased alive on November 2, 1959 , and that death occurred at 6:21 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 11/2/59 DATE SIGNED | | | | | | | | |
| ACTUAL SIGNATURE <i>Jerry S. Trier</i> | | M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland | | | | | | |
| PHYSICIAN'S NAME (Type) Jerry S. Trier, M.D. | | | | | | | | |
| 22a. BURIAL, CREMATON, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Nov. 4, 1959 | | 22c. NAME OF CEMETERY OR CREMATORIUM King David Memorial Garden | | 22d. LOCATION (City, town, or county) (State) Falls Church, Virginia | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons | | ADDRESS 3501 14th Street, N.W. | | 24a. REC'D BY REGISTRAR NOV 4 '59 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> | | |



12820

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

| | | | | | | | | |
|---|---|--|---|---|--|--------------------------------------|--------------------------------|------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | c. LENGTH OF STAY IN 1b DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dayton | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery County Gen. Hosp. | | | | d. STREET ADDRESS | | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First Mark | Middle Allen | Last Trail | 4. DATE OF DEATH 11/20/59 | Month 11 | Day 20 | Year 19 |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 9/29/56 | 9. AGE (in years to nearest birthday) 3 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. Days 0 | Hours Min. 00 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | |
| 13. FATHER'S NAME Gerald Trail | | | | 14. MOTHER'S MAIDEN NAME Mable E. Johnson | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Hosp Record | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Acute peritonitis PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Rupture of peptic ulcer of stomach DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH one week | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i> | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | | DATE SIGNED 11/20/59 | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 11-23-59 | | 22c. NAME OF CEMETERY OR CREMATORIAL Linthicum Chapel | | 22d. LOCATION (City, town, or county) (State) Clarksville, Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md. | ADDRESS | | 24a. REC'D BY REGISTRAR NOV 23 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Krause | | | |



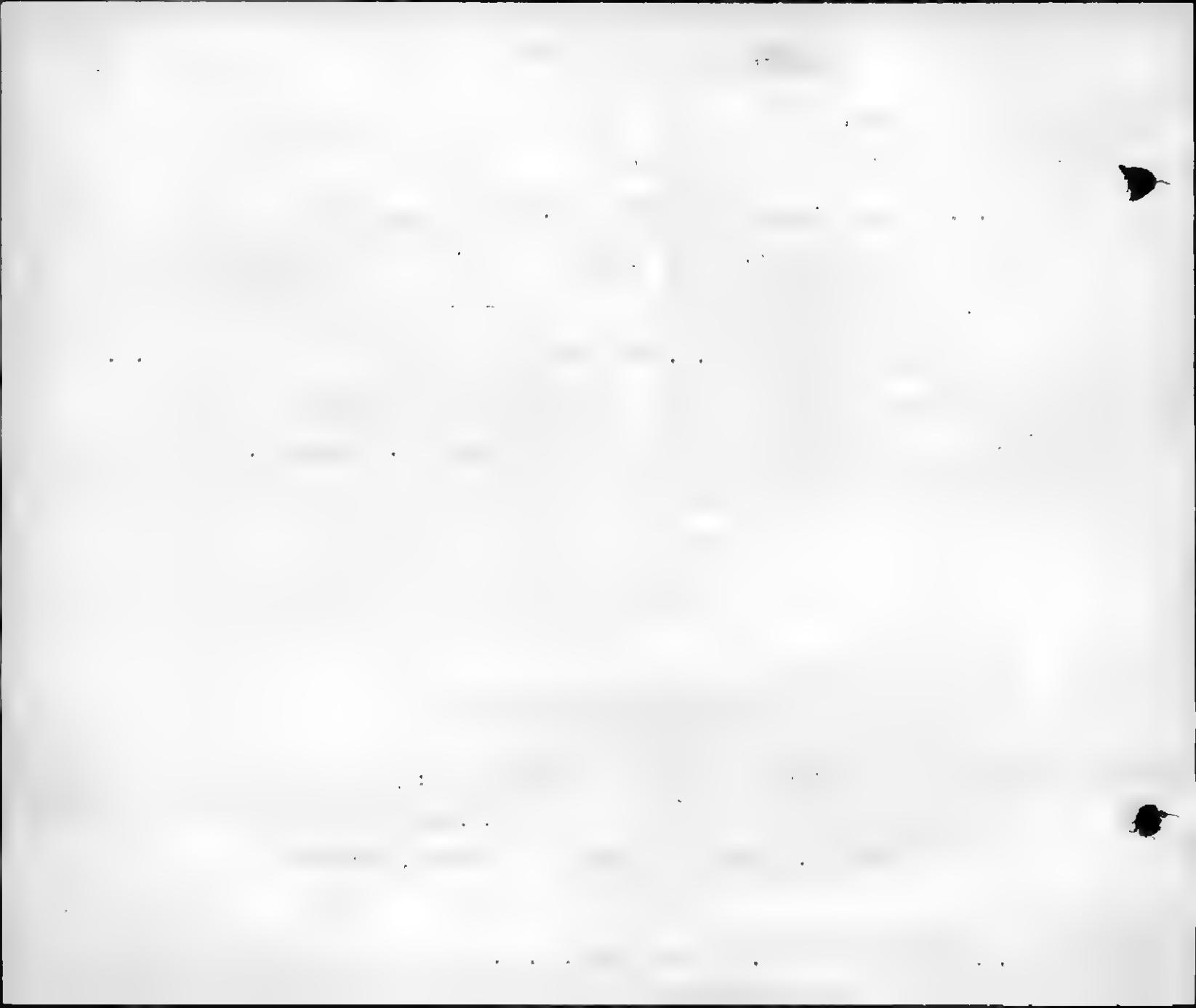
12821

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | | | | | | | | |
|---|----------------------------------|---|----------------------------------|--|---|---|---------------------------|-------------------------|-------|---------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 30 days | | 2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE Virginia | | b. COUNTY V | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital Bethesda, Md. | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington | | d. STREET ADDRESS 315 No. Piedmont St. | | | | | | |
| 3. NAME OF DECEASED (Type or print) Ferdinand | | First | Middle | Last | 4. DATE OF DEATH November 29 1959 | Month | Day | Year | | | | |
| S. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> | DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-19-87 | 9. AGE (In years last birthday) 72 yrs | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Days | Hours | Min | | |
| 10a. JSLAL OCCUPATION (Give kind of work done during most of working life, even if retired) NAVY | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Government | | 11. BIRTHPLACE (State or foreign country) Louisiana | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | |
| 13. FATHER'S NAME Elphege TRICHE | | | | 14. MOTHER'S MAIDEN NAME Corine BLANCHER | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. WW T&T | | INFORMANT (wife) Mrs. Nellie P. TRICHE | | Address | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Melanotic carcinoma</i> 154x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Adenocarcinoma, rectum</i> DUE TO (c) | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | |
| 21. I certify that I attended the deceased from 30 October 1959 to 29 November 1959 at I last saw the deceased alive on 29 November 1959 , and that death occurred at 10:45A from the causes and on the date stated above. | | | | | | | | | | | ADDRESS (Street, city or town, state) | DATE SIGNED |
| ACTUAL SIGNATURE <i>Robert C. Thomas</i> | | M.D. U.S. Naval Hospital, NNMC | | | | | | | | | 30 Nov 59 | |
| PHYSICIAN'S NAME (Type) Robert C. THOMAS, LT MC USN | | Bethesda, Maryland | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-3-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NATIONAL | | 22d. LOCATION (City, town, or county) Arlington, Virginia | | (State) | | | | |
| 23. FUNERAL DIRECTOR'S NAME (Type) S.H.HINES 2901 14th St. NW, Washington, D. C. | | ADDRESS Kingsway Corp | | | | | | | | | 24a. REG'D BY REGISTRAR Dec 2 1959 | 24b. REGISTRAR'S SIGNATURE Frank J. Muller |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12822

12839 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Mont.

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Germantown

c. LENGTH OF STAY IN lb

5 Mo

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

The Marylander.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE

Maryland

b. COUNTY

C. ty.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

17 Tacoma Park.

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATHMonth
NOVDay
19Year
1959

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
lost birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS

M

1c

White

WIDOWED DIVORCED

Mar 11-1952

77 yrs.

Months

8

Days

8

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Contractor

10b. KIND OF BUSINESS OR INDUSTRY

Building

11. BIRTHPLACE (State or foreign country)

Glover. d.

12. CITIZEN OF WHAT COUNTRY?

J S A

13. FATHER'S NAME

William H. Wade

14. MOTHER'S MAIDEN NAME

Ellen Koy

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT

Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

493X

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Pneumonia, Bilateral

INTERVAL BETWEEN
ONSET AND DEATH

3 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day Year
Hour o. m.
p. m. 1920d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Nov. 10, 1959, to Nov. 19, 1959, that I last saw the deceased
alive on Nov. 18, 1959, and that death occurred at 8:00 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Vernon E. Martens M.D. Germantown Nov. 19, '59

PHYSICIAN'S
NAME (Type)

Vernon E. Martens

22a. BURIAL, CREMATION,
REMOVAL (Specify)22b. DATE THEREOF
Burial 11-21-5922c. NAME OF CEMETERY OR CREMATORIUM
St Rose

22d. LOCATION (City, town, or county)

(State)

Glover. Gaithersburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Ernest B. Hartman Gaithersburg, Md.

24b. REC'D BY REGISTRAR
NOV 23 '59
DATE24b. REGISTRAR'S SIGNATURE
Arthur S. Kline



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12823

12840

CERTIFICATE OF DEATH

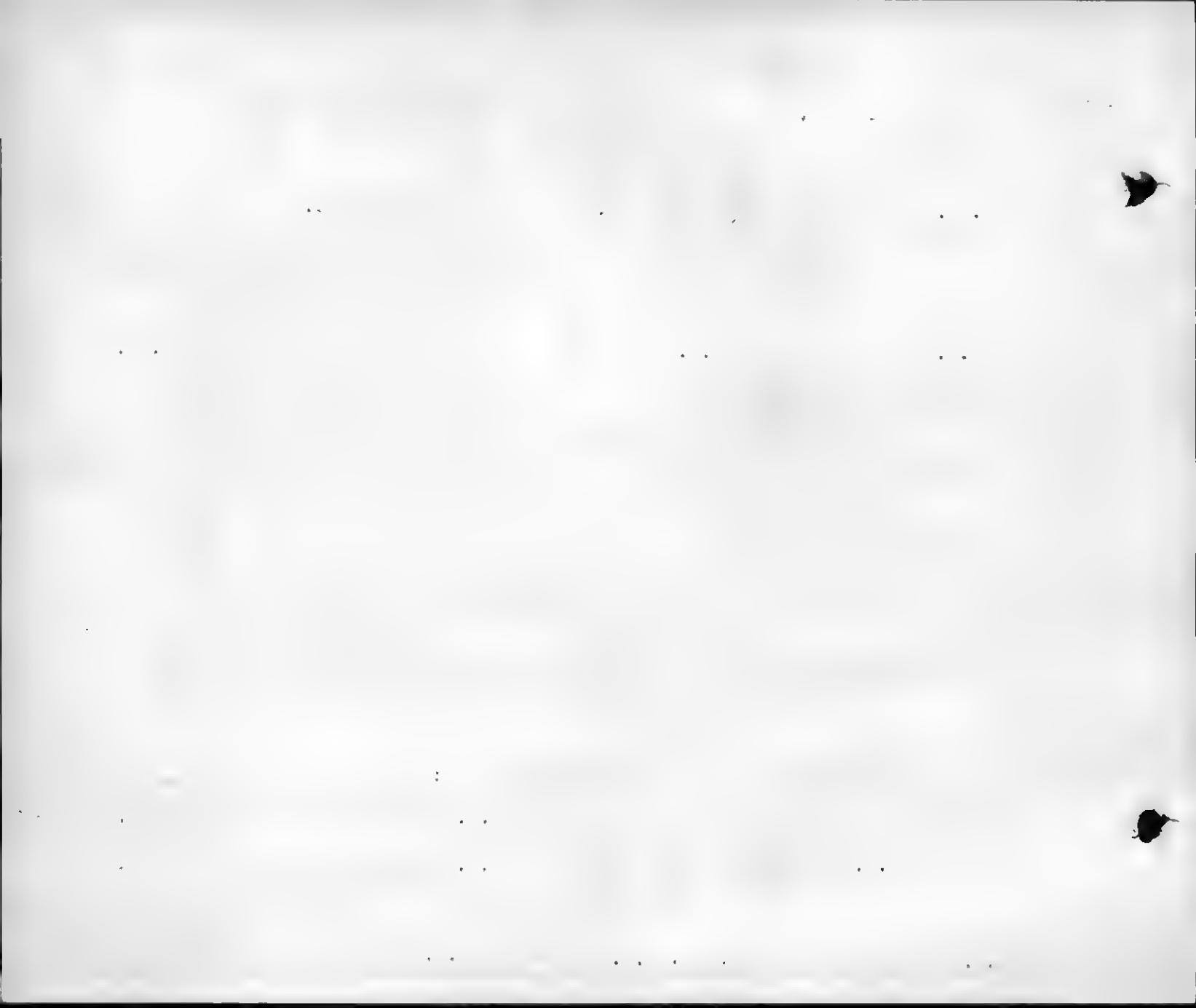
Reg. Dist. No. 215

| | | | | | | | | | | |
|--|----------------------------------|---|--|--|---|---|-------|------|---|-------------|
| 1. PLACE OF DEATH o. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived - If institution Residence before admission) o STATE West Virginia | | b. COUNTY | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN lb 70 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkerburg | | d. STREET ADDRESS 1801 Broadway Ave. | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda Md. | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) | First Vere | Middle Curtis | WALBROUN | Last | 4. DATE OF DEATH November 13 1959 | Month | Day | Year | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | B. DATE OF BIRTH 2-26-27 | 9. AGE (in years last birthday) 32 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Days | Hours | Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Government | | 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? U. S. | | | | |
| 13. FATHER'S NAME Wilbur Walbroun | | | 14. MOTHER'S MAIDEN NAME Bertie Richards | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO 235 40 9075 | | INFORMANT Official Government Records | | Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 445X Conditions, if any which gave rise to immediate cause (o), stating the underlying cause last DUE TO (b) DUE TO (c) DUE TO (d) Diseases + 1/2 portion of 11 months (deceased) late as to over + too long + upper left arm, 3 yr. (Chronic Obstructive Neuritis) | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I attended the deceased from <u>4 September, 1959</u> , to <u>13 November, 1959</u> , that I last saw the deceased alive on <u>13 November, 1959</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above. | | | | | | | | | ADDRESS (Street, city or town, state) | DATE SIGNED |
| ACTUAL SIGNATURE <i>J. W. C. m. 68</i> | | M.D. U.S. Naval Hospital, Bethesda Md. 11-14-59 | | | | | | | | |
| PHYSICIAN'S NAME (Type) F.H. O'Connell LCDR MC USN | | U.S. Naval Hospital, Bethesda Md. | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/19/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Parkersburg Cemetery | | 22d. LOCATION (City, town, or county) (State) Parkersburg, West Virginia | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers</i> | | ADDRESS 1400 Chapin St. N.W. Washington, D.C. | | 24a. REC'D BY REGISTRAR NOV 19 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | | | | |

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by me Funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12824

12841

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | |
|---|----------------------------------|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | b. COUNTY Montgomery | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | c. LENGTH OF STAY IN 1b 10 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Gaithersburg | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montg. Co. Gen. Hospital | | d. STREET ADDRESS RFD #1, Box 90 | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) John S. Ward, Sr. | | First | Middle | Last | 4. DATE OF DEATH November 12 1959 | Month | Day | Year |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 22, 1882 | 9. AGE (In years last birthday) 77 yrs. | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS. Hours | 12. Days | 13. Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired engineer | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Eng. Corp. | | 11. BIRTHPLACE (State or foreign country) Woodfield, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME William Ward | | 14. MOTHER'S MAIDEN NAME Hennie Purdum | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 578-32-4280 | | 17. INFORMANT Mrs Bertha D. Ward, Gaithersburg, Md. | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Intercostal arteriovenous fistula (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 17 days | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 5/24 , 19 59 , to 11/12 , 19 59 , that I last saw the deceased alive on 11/11 , 19 59 , and that death occurred at 6:55 AM , from the causes and on the date stated above. ACTUAL SIGNATURE James P. Kerr M.D. | | | | | | ADDRESS (Street, City or town, State) Damascus, Md. | | |
| PHYSICIAN'S NAME (Type) James P. Kerr, M.D. | | | | | | DATE SIGNED 11/12/59 | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/15/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Oakwood Cemetery | | 22d. LOCATION (City, town, or county) Falls Church, Va. | | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Molesworth | | ADDRESS Damascus, Md. | | 24a. REC'D BY REGISTRAR DATE NOV 16 '59 | | 24b. REGISTRAR'S SIGNATURE John S. Ward | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

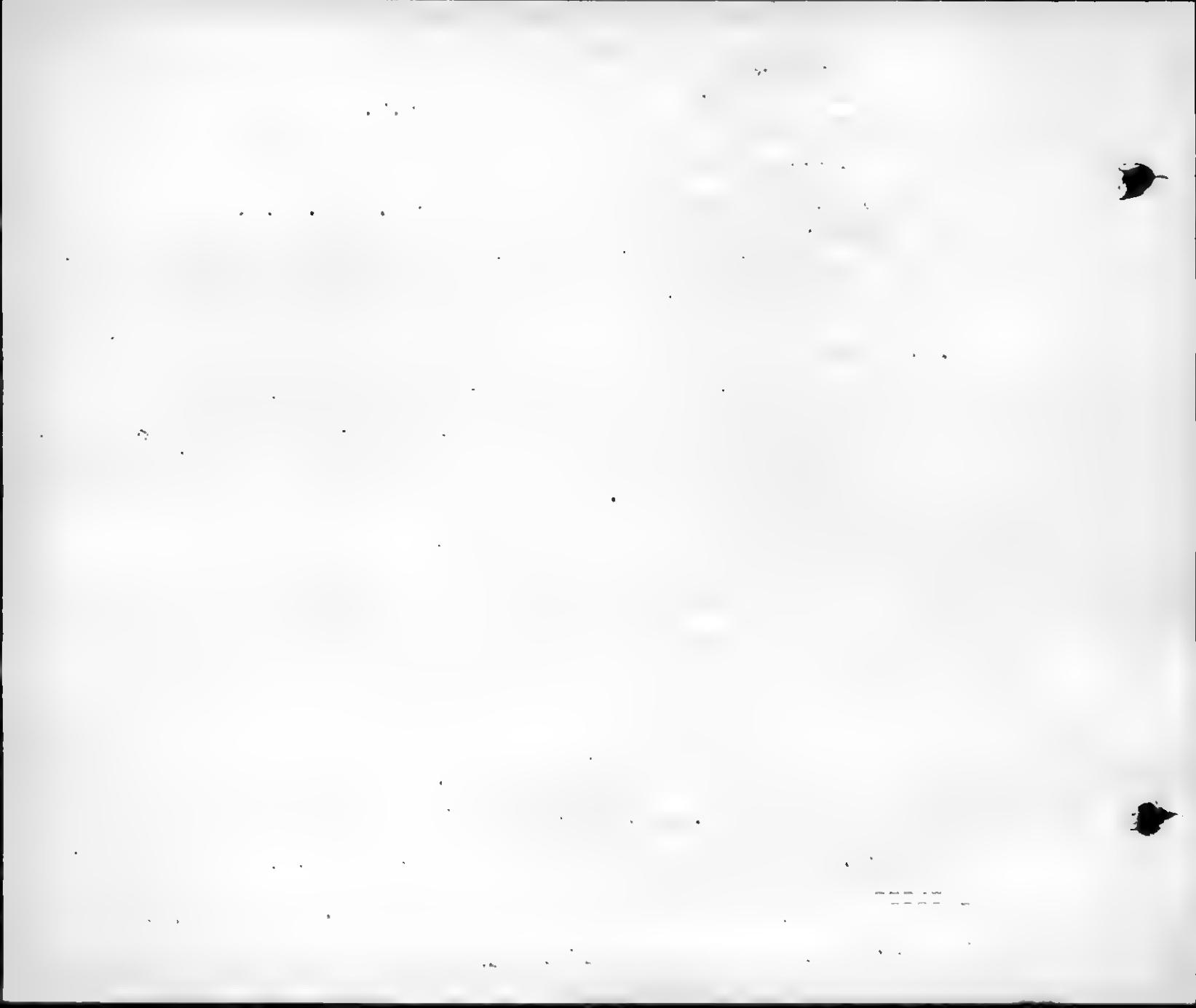
12825

12842 CERTIFICATE OF DEATH

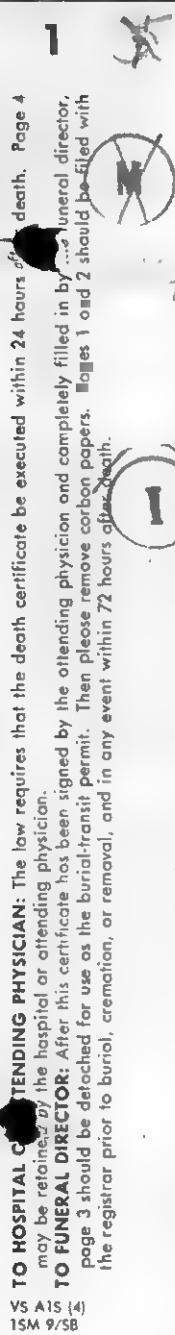
Reg. Dist. No.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Council Hall Cemetery Montgomery Co.</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> | |
| d. LENGTH OF STAY IN 1b <i>RURAL</i> | | e. STREET ADDRESS <i>2900 Conn. Ave. N.W.</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Council Hall Cemetery</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First <i>Mareta</i> | Middle <i>Mareta</i> | Watson Last <i>Watson</i> |
| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH ? |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i> | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME <i>Charles Mc Allister</i> | 14. MOTHER'S MAIDEN NAME <i>Laura Bowman</i> | INFORMANT M. E. <i>Mrs. Priscilla Smith</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | 16. SOCIAL SECURITY NO. | Address <i>1024 1/4 Ave N.W.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Carcinoma of lung</i> | | | |
| DUE TO (b) DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from _____ to _____ that I last saw the deceased alive on _____, and that death occurred at _____ M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE <i>Erwin Steinman M.D.</i> | ADDRESS <i>3500-14th St. N.W.</i> | | |
| PHYSICIAN'S NAME (Type) <i>ERWIN STEINMAN M.D.</i> | Washington 10 DC | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>11/19/59</i> | 22b. DATE THEREOF <i>11/19/59</i> | 22c. NAME OF CEMETERY OR CREMATORIUM <i>Glenwood Cemetery</i> | 22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>S. H. Hines Co. 2901-14th h.w.</i> | ADDRESS | 24a. REC'D BY REGISTRAR DATE NOV 19 '59 | 24b. REGISTRAR'S SIGNATURE <i>C. L. Hines</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



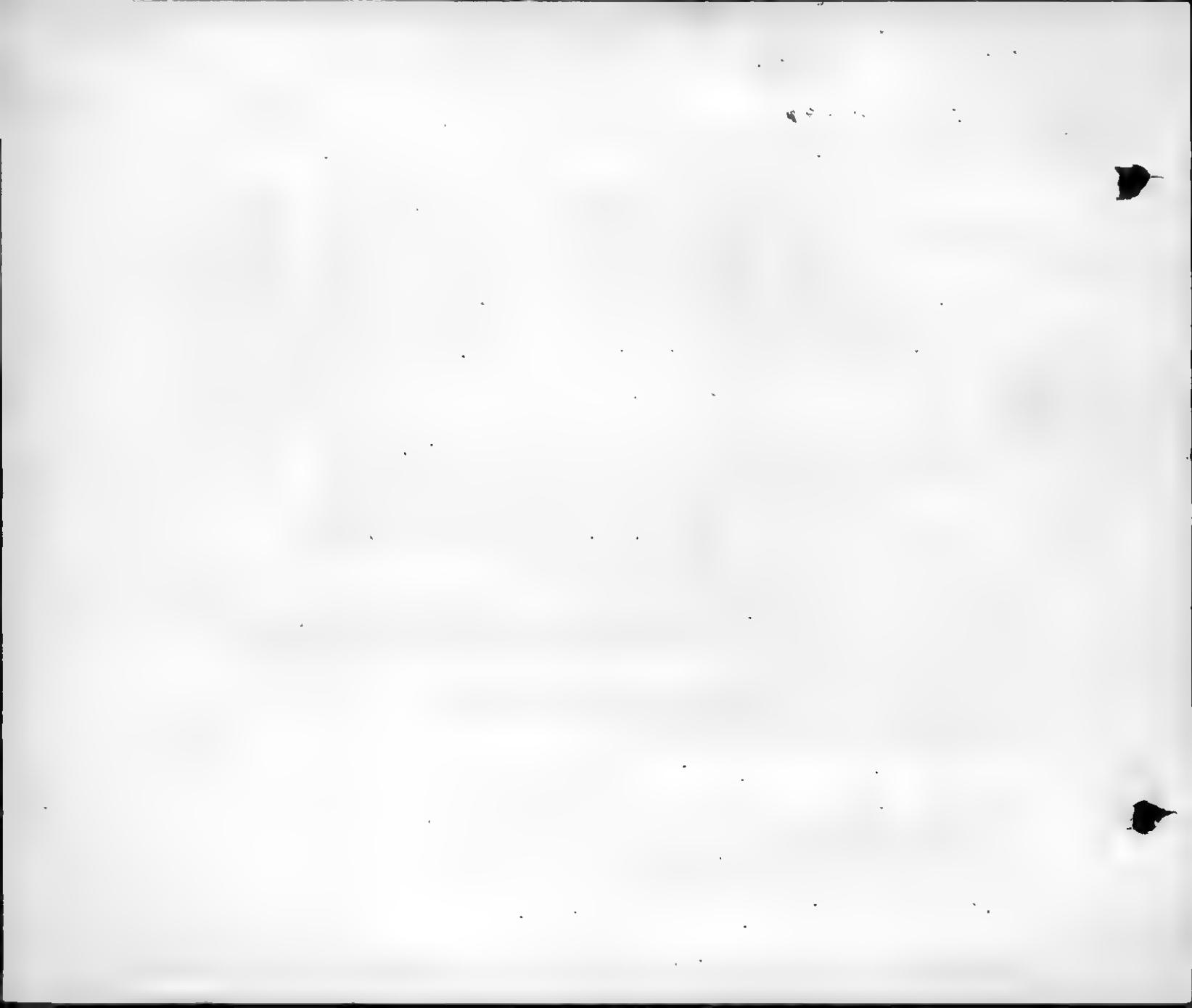
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G-52 12-1-59 et
 12843 CERTIFICATE OF DEATH

12826

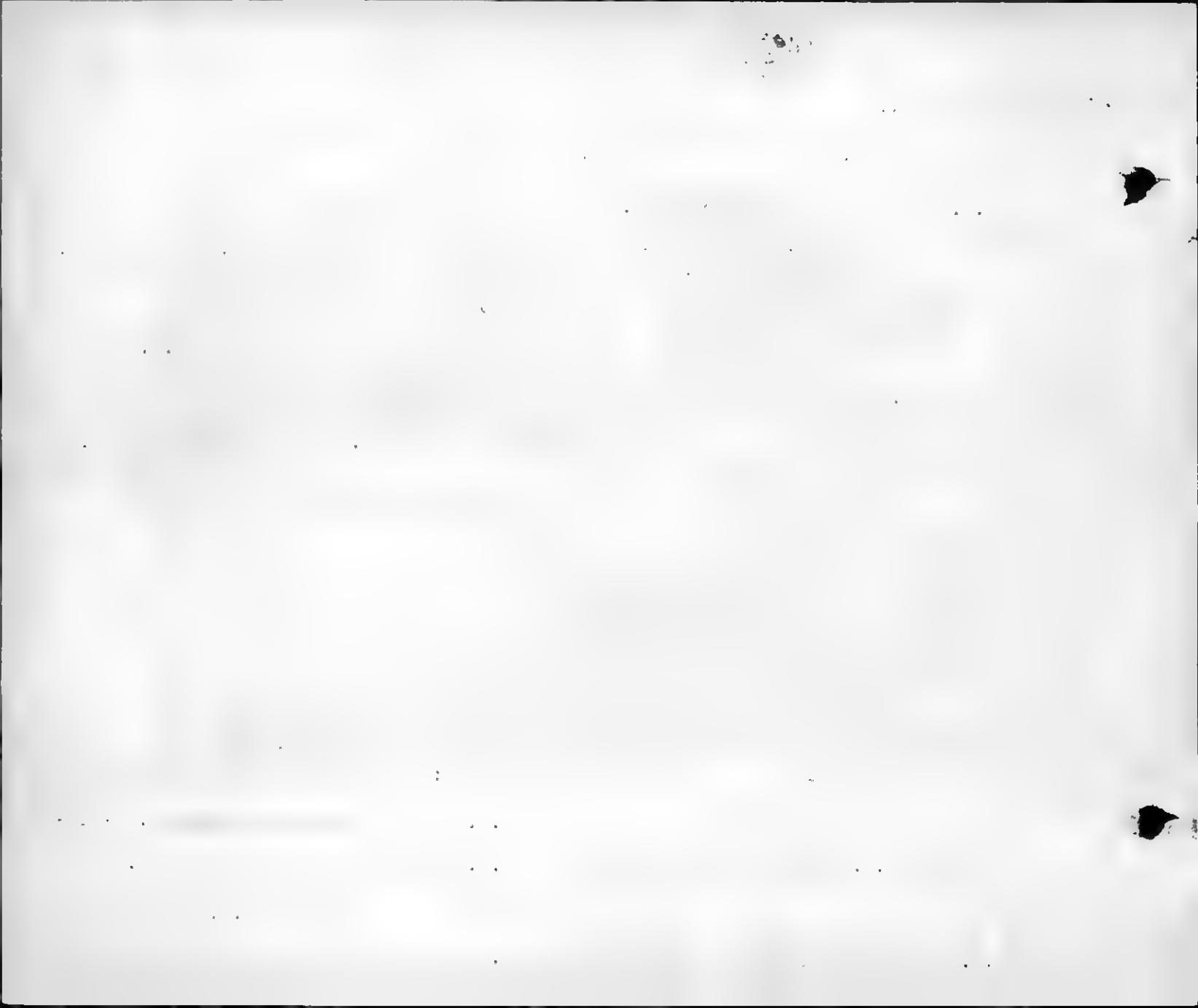
Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--------------------------------------|---|---------------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND | | b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA | | c. LENGTH OF STAY IN 1b 14 hrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XCHELY CHASE | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN Hospital | | e. STREET ADDRESS 155 E. QUINCY STREET | | f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First JENNIE P | Middle | Last WAY | 4. DATE OF DEATH | Month 11 | Day 18 | Year 1959 |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-28 1875 | 9. AGE (In years last birthday) 84 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS Hours 0 | IF UNDER 24 HRS Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY Homemaking | | 11. BIRTHPLACE (State or foreign country) PENNA. | | 12. CITIZEN OF WHAT COUNTRY? USA - | |
| 13. FATHER'S NAME Proach | | 14. MOTHER'S MAIDEN NAME Margaret Prough | | Address SAME AS ABOVE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. | | INFORMANT MR. H.E. WAY | | 17. INTERVAL BETWEEN ONSET AND DEATH 12 Hours | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) (c) | | DUE TO Hypocardial Infarction, posterior | | Thrombosis Posterior Coronary Artery | | 13 hours | |
| | | DUE TO Arteriosclerosis | | | | years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia left heart; Conduction obstructive & oblongitis | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from Dec , 1957, to Nov 18 , 1959 that I last saw the deceased alive on Nov 17 , 1959, and that death occurred at 3:15 A.M., from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) George Sherpe MD 10511 Summit Ave Kensington, Md | | | | | | | |
| DATE SIGNED 11/18/59 | | | | | | | |
| ACTUAL SIGNATURE George Sherpe | | M.D. | | | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/21/59. | | 22c. NAME OF CEMETERY OR CREMATORIAL Fairview | | 22d. LOCATION (City, town, or county) Altamira, Penna | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Albert A. Adams | | ADDRESS 4748-Wisene Adams Funeral Home Washington D.C. | | 24a. REC'D BY REGISTRAR NOV 20 '59 | | 24b. REGISTRAR'S SIGNATURE C. J. S. Kline | |



TO HOSPITAL CERTIFYING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | | | Reg. Dist. No. 215 | | | |
|---|--|---|--|---|-----------------------------------|--|---|---|---|--|--|---|--|-------------|--|
| 12844 Items 8,9 Film G253 12-3-59 et | | | | | | | | | | | | 12827 | | | |
| PLACE OF DEATH | | | | | | CERTIFICATE OF DEATH | | | | | | | | | |
| a. COUNTY Montgomery | | | MARYLAND | | | 2. USUAL RESIDENCE [Where deceased lived. If institution Residence before admission] | | | b. STATE Virginia | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | c. LENGTH OF STAY IN 1b 40 minutes | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church | | | d. STREET ADDRESS 2411 Hemlock Drive | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md. | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First Lucille | | Middle Keats | | Last WHARTON | | 4. DATE OF DEATH November 15 1959 | | Month Day Year | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 10-5-46 1908 | | 9. AGE (In years last birthday) 48 51 yrs | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | | 11. BIRTHPLACE (State or foreign country) Ohio | | | | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 13. FATHER'S NAME Harold G. Keats | | | | | | 14. MOTHER'S MAIDEN NAME Ella Meenan | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO. | | | INFORMANT | | | Address | | | | | | |
| No | | | | | | (Husband) Claude A. Wharton Same as #2 | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 330X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO } (c) | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.) | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | | 20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | | | | | |
| 21. I certify that I attended the deceased from 15 November, 1959, to 15 November 1959, that I last saw the deceased alive on 15 November, 1959, and that death occurred at 9:40P M, from the causes and on the date stated above. | | | | | | | | | | | | ADDRESS (Street, city or town, state) | | DATE SIGNED | |
| ACTUAL SIGNATURE M.E. ALLISON JR | | M.D. U.S. Naval Hospital, Bethesda Md. 11-16-59 | | | | | | | | | | | | | |
| PHYSICIAN'S NAME (Type) | | M.E. ALLISON JR LCDR MC USN | | | U.S. Naval Hospital, Bethesda Md. | | | | | | | | | | |
| 22a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11-18-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Arlington National | | | 22d. LOCATION (City, town, or county) Arlington V.a. | | | (State) | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R.T. Murphy | | ADDRESS 3524 Columbia Pike Arlington Va. | | | | | | 24a. REC'D BY REGISTRAR DATE NOV 19 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Haas | | | | | |



TO HOSPITAL or **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Items 8 & 9. F-2-1 J-251 L-1, 1959.cac. | | | | | | | | | | 12828 | |
|---|--|--|--|--|--|---|--|--|--|---------------------------------|--|
| 12845 Item 14 11-14-59 et | | | | | | | | | | Reg. Dist. No. | |
| 1. PLACE OF DEATH a. COUNTY | | MONTGOMERY | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | Silver Spring | | c. LENGTH OF STAY IN 1b | | a. STATE D.C. | | b. COUNTY | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | Marilee Nursing Home | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | WASHINGTON 47 | | | |
| 3. NAME OF DECEASED (Type or print) | | First LAURA | | Middle E. | | Last WHEELER | | 4. DATE OF DEATH | | Month Nov 2 | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. AGE (In years last birthday) 86 yrs | | IF UNDER 1 YEAR IF UNDER 24 HRS | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY own home | | 11. BIRTHPLACE (State or foreign country) Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME Samuel Baker Johnson | | 14. MOTHER'S MAIDEN NAME Unknown | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Mr. Thomas E. Wheeler, Deale, Maryland | | Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | 422.1 DUE TO | | Chest infection with pneumonia | | 1/2 hrs | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) DUE TO | | Chronic - myocardial disease | | 4 weeks | | | | | |
| (c) DUE TO | | Slight chest cold | | and coronary heart disease | | days | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Washington, D.C. | | (County) | | (State) | |
| 21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____ M.D., from the causes and on the date stated above. | | | | | | | | ADDRESS (Street, city or town, state) | | DATE SIGNED | |
| ACTUAL SIGNATURE <i>John S. Rogers</i> | | | | | | | | 5718 30th, Maryland 11-2-59 | | | |
| PHYSICIAN'S NAME (Type) JOHN S. ROGERS | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 11/5/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM MT. OLIVET CEMETERY | | 22d. LOCATION (City, town, or county) WASHINGTON, D.C. | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. <i>Raymond A. Zisk</i> | | ADDRESS SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR NOV 9 '59 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 File #252 11-27-59 et

12846

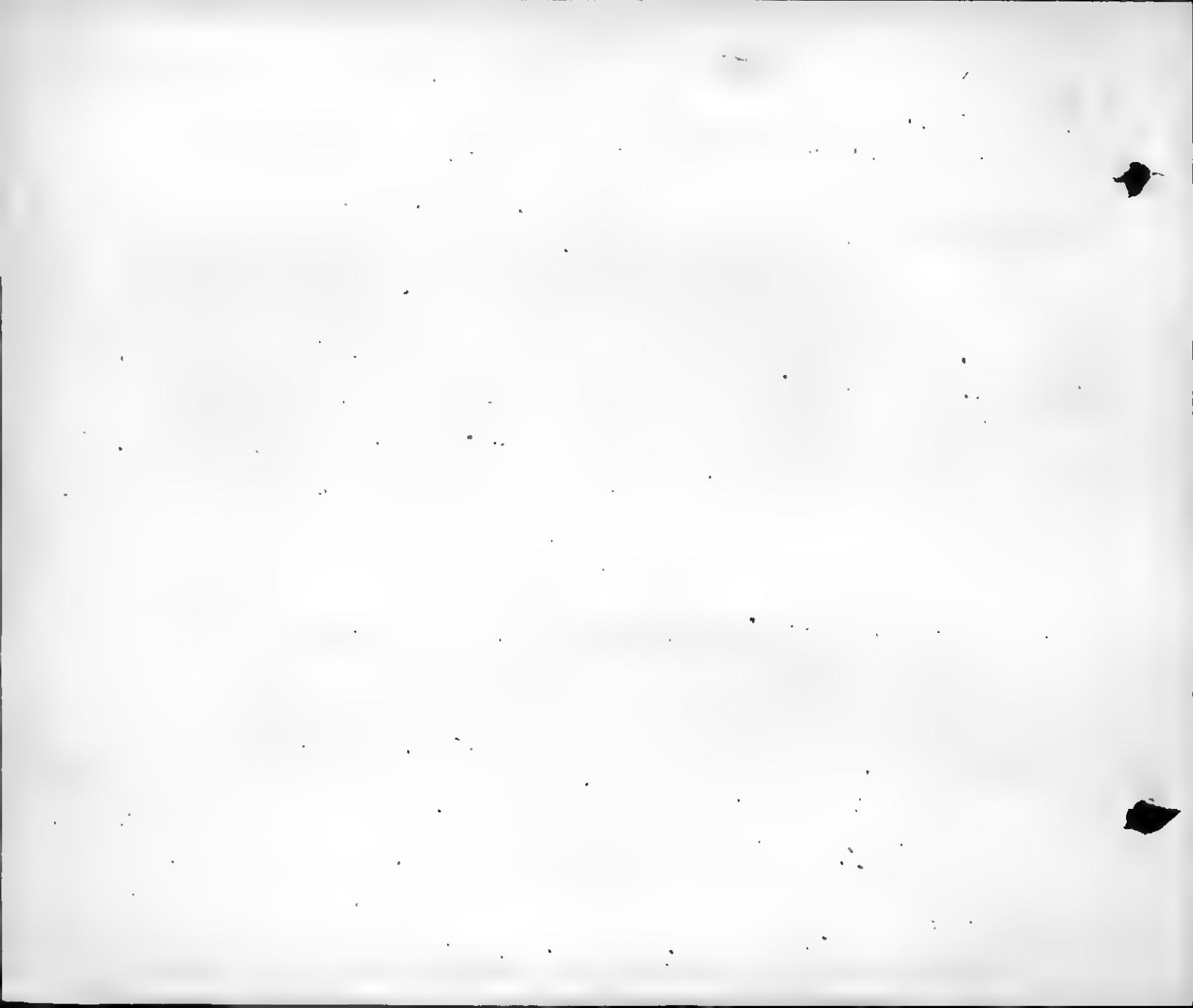
CERTIFICATE OF DEATH

Reg. Dist. No.

12820

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery County</i> | | 2. USUAL RESIDENCE WHERE deceased lived. If institution: Residence before admission a. STATE <i>MD</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda Rd., Bethesda, Md.</i> | | c. LENGTH OF STAY IN 1b RURAL and give nearest town <i>3 years</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Congressional Hospital, 3200 White St., Bethesda, Md.</i> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> | |
| f. STREET ADDRESS <i>705 18th St.</i> | | g. DATE OF DEATH Month Day Year <i>11 21 1959</i> | |
| h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <i>Last name: White Middle: Daisy</i> | | 4. DATE OF DEATH Month Day Year <i>11 21 1959</i> | |
| 5. SEX <i>F</i> | | 6. COLOR OR RACE <i>21</i> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>10/6/79</i> | |
| 9. AGE (In years last birthday) <i>80 yrs</i> | | 10. IF UNDER 1 YEAR Months Days Hours Min. <i>0 0 0 0</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during non or working life, even if retired) <i>Retired</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Housekeeper (part time)</i> | |
| 10c. BIRTHPLACE (State or foreign country) <i>Benton Harbor, Mich.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Wright E. Wright</i> | | 14. MOTHER'S MAIDEN NAME <i>Margaret Fielder</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>no</i> | |
| 17. INFORMANT <i>Mrs. J.W. Gibson</i> | | 18. ADDRESS <i>Belvedere Apts 13 - at Maryland Rockville, Md.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO <i>Generalized arteriosclerosis</i> years (c) DUE TO <i>Hypertension</i> years | | 19. INTERVAL BETWEEN ONSET AND DEATH <i>10 hours</i> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Atherosclerotic heart disease; pyelitis</i> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Pyelitis</i> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>809 Veirs Mill Rd.</i> | | 20f. (City or town) (County) (State) <i>Rockville, Md.</i> | |
| 21. I certify that I attended the deceased from <i>July 1956</i> to <i>Nov. 20, 1959</i> that I last saw the deceased alive on <i>Nov. 20, 1959</i> , and that death occurred at <i>2:45 AM</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>G. Bowditch Hunter, Jr. M.D.</i> | | ADDRESS (Street, city or town, state) <i>809 Veirs Mill Rd. 11/21/59</i> | |
| DATE SIGNED <i>11/21/59</i> | | | |
| PHYSICIAN'S NAME (Type) <i>G. Bowditch Hunter, Jr. M.D.</i> | | | |
| 22a. BURIAL/CREMATION, REMOVAL (Specify) <i>11/23/59</i> | | 22b. DATE THEREOF <i>11/23/59</i> | |
| 22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Paul's</i> | | 22d. LOCATION (City, town, or county) <i>Takoma Park</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John Lark</i> | | 24a. REC'D BY REGISTRAR DATE NOV 24 '59 | |
| ADDRESS <i>Easton, Md.</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12847

CERTIFICATE OF DEATH

Reg. Dist. No.

12850

1. PLACE OF DEATH

o. COUNTY Montgomery Co MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda 1 day

c. LENGTH OF STAY IN 1b
RURAL and give nearest town

Suburban

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Md.

b. COUNTY Co.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

56 Silver Spring, Md.

d. STREET ADDRESS

1406 - Burnt Mills Ave

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First Jean

Middle L.

Last Wilkes

4. DATE
OF
DEATH

Month Nov.

Day 9

Year 1959

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

51 yrs.

10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

11. KIND OF BUSINESS OR INDUSTRY

12. BIRTHPLACE (State or foreign country)

13. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Robert F. Ross Jr.

14. MOTHER'S MAIDEN NAME

Mathilda Chambord

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unknown)

(If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

577-46-5839

INFORMANT

Address 406-Burnt Mills Ave

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a)

170X

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

PULMONARY METASTASES

INTERVAL BETWEEN
ONSET AND DEATH
6 WEEKS

CARCINOMA OF BREAST

5 YEARS

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

NONE

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.20d. INJURY OCCURRED
While at work Not while at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from AUG 15, 1959, to NOV. 9, 1959, that I last saw the deceased alive on NOV. 9, 1959, and that death occurred at 5 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type)

John H. Tuchy

M.D.

7720 Wisconsin Ave

11/9/59

BETHESDA 14, MD.

22b. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM 22d. LOCATION (City, town, or county) (State)

BURIAL

11/12/59

Parklawn Cemetery

Silver Springs

Md.

23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Z. ADDRESS Silver Spring Md. REC'D BY REGISTRAR NOV 13 '59

Warren E. Humphrey Inc. 8434 Georgia Ave

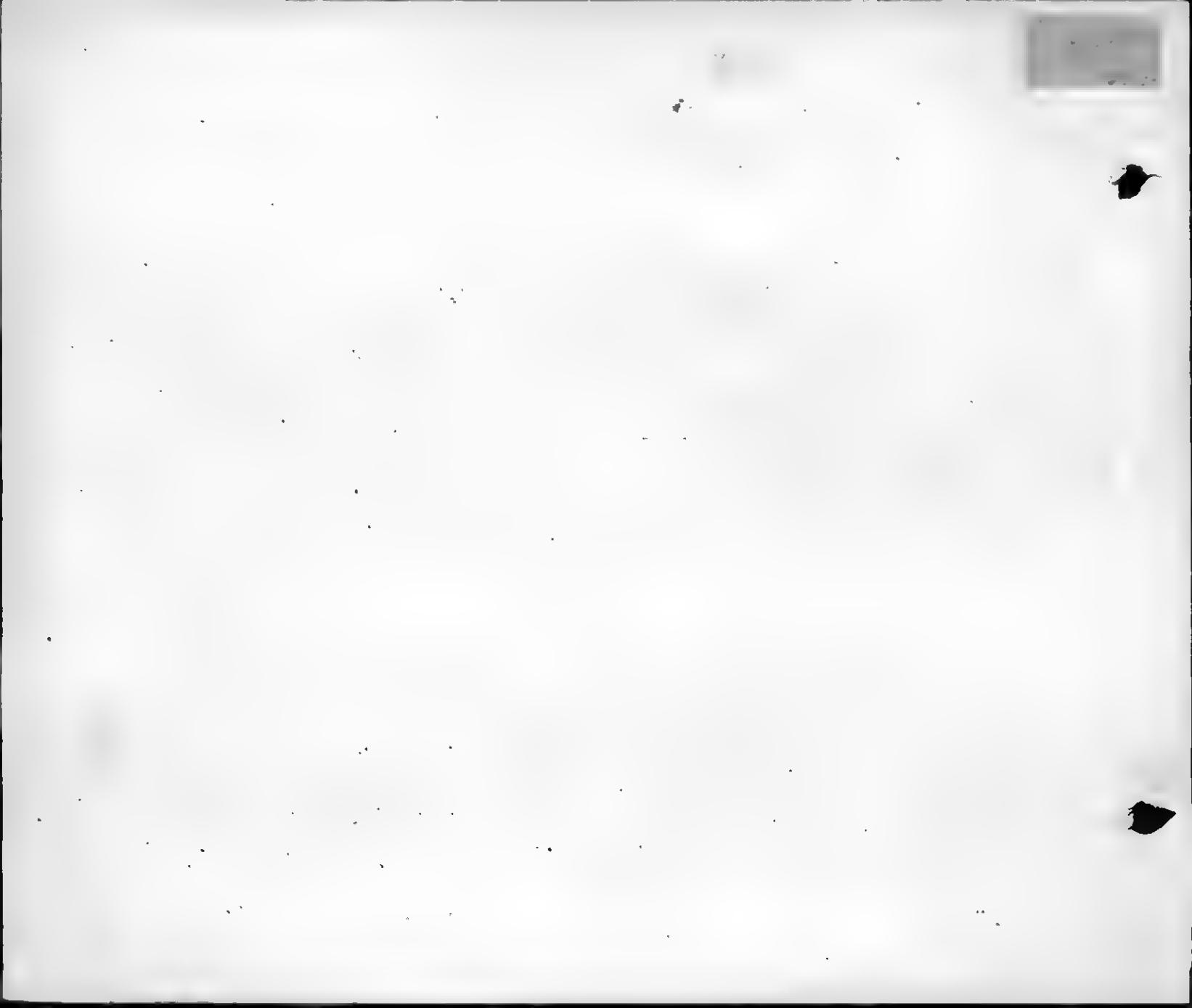
DATE

11/9/59

united & sons

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12693

CERTIFICATE OF DEATH

Reg. Dist. No.

12831

| | | | | | | | | |
|--|---------------------------------|---|-------------------------------------|---|--|---|--------------------------------------|------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE An District of Columbia | | b. COUNTY Columbia | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | c. LENGTH OF STAY IN 1b 1 day | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | d. STREET ADDRESS 1450 Newton St., NE 2059 | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Montefiore Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) Sarah Catherine Willard | | First | Middle | Last | 4. DATE OF DEATH Month November | Day 3 | Year 1959 | |
| 5. SEX F | 6. COLOR OR RACE Cauc | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/23/68 | 9. AGE (In years last birthday) 90 yrs | 10. IF UNDER 1 YEAR Months 0 | Days 0 | IF UNDER 24 HRS Hours 0 | Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWF | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Penn. | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Gerald Osman | | 14. MOTHER'S MAIDEN NAME Mary Laudenslager | | Address | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Hospital Record | | INTERVAL BETWEEN ONSET AND DEATH 1 yr | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 492.1 DUE TO Diabetes Mellitus | | (b) | | (c) Old age + Senility (90 only) | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. | | DUE TO | | Old age + Senility (90 only) | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Old residual C.V. disability | | | | | | |
| 20a. ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from alive on Nov 3 1959 , and that death occurred at 9:45 PM , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) 7600 Carroll Ave DATE SIGNED 11/21/59 | | | | | | |
| ACTUAL SIGNATURE Chas H. Wolfrom | | M.D. Tolson Park Dr | | | | | | |
| PHYSICIAN'S NAME (Type) Chas H. Wolfrom | | | | | | | | |
| 22a. BURIAL, CREMATION, OR REMAINS AS SPECIFIED Burial | | 22b. DATE THEREOF 11/7/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Wines Co. n.w. Washington | | ADDRESS 2901-14th St 24e. REC'D BY REGISTRAR DATE NOV 5 '59 24b. REGISTRAR'S SIGNATURE J. E. St. James | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12848

CERTIFICATE OF DEATH

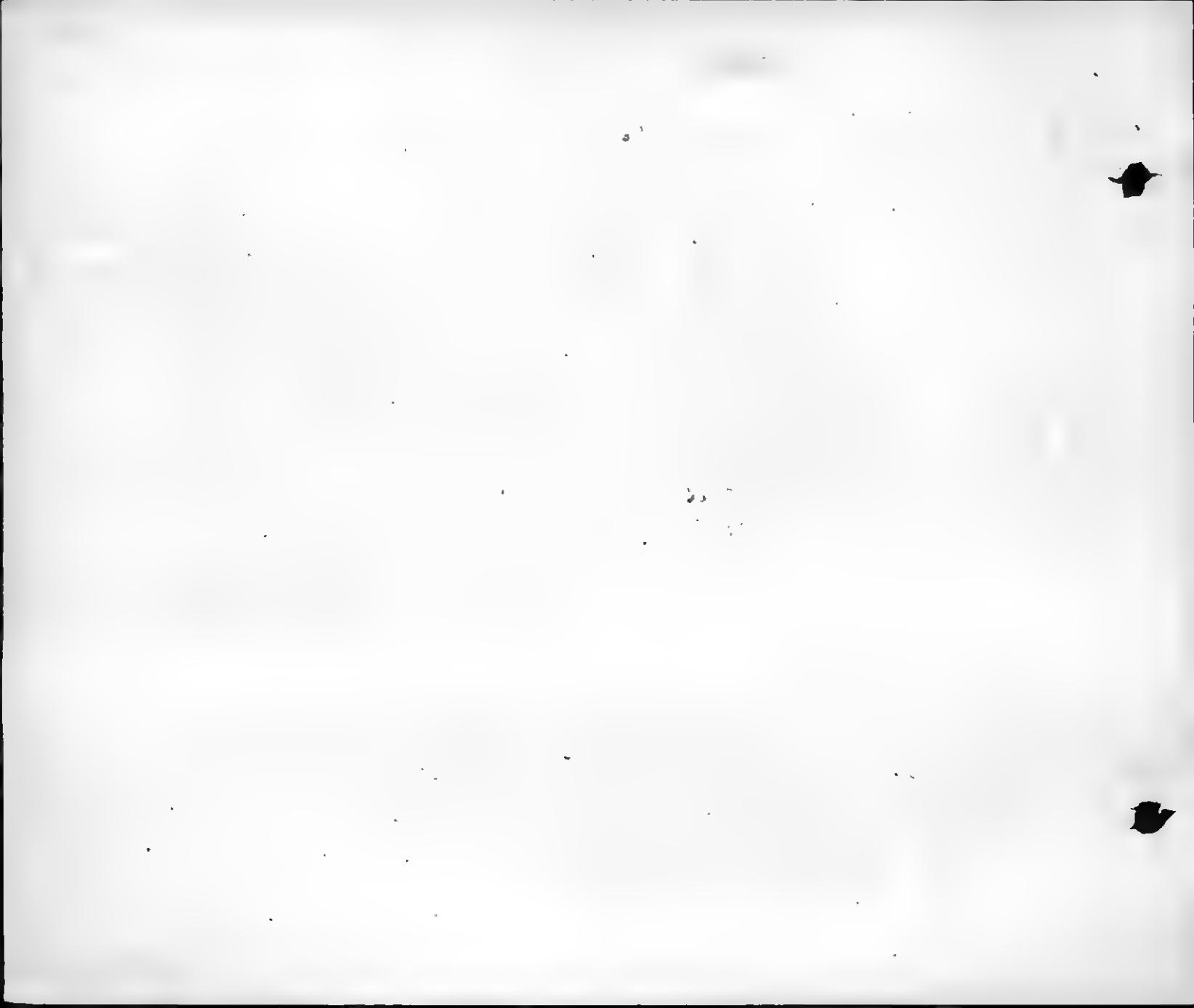
Reg. Dist. No.

12832

TO HOSPITAL CERTIFYING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) d. STATE <i>Maryland</i> | | b. COUNTY <i>Montgomery</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda, Md.</i> | | c. LENGTH OF STAY IN lb <i>25 yrs.</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Bethesda, Md.</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7402 Fairfax Rd., Beth., Md. MUNRO</i> | | d. STREET ADDRESS <i>7402 Fairfax Rd., Bethesda, Md.</i> | | 4. DATE OF DEATH Month <i>11</i> | | Day Year <i>28 1959</i> | |
| 3. NAME OF DECEASED (Type or print) <i>Ronald A. Wilson</i> | | First Middle Last | | 5. SEX <i>Male</i> | | 6. COLOR OR RACE <i>White</i> | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>June 4 1891</i> | | 9. AGE (In years last birthday) <i>68 yrs.</i> | | 10. IF UNDER 1 YEAR Months <i>5</i> Days <i>24</i> Hours <i>0</i> Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Civil Engr.</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Dept. of Interior</i> | | 11. BIRTHPLACE (State or foreign country) <i>Quincy, Massachusetts</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Daniel Munro Wilson</i> | | 14. MOTHER'S MÄDEN NAME <i>Ella C. Hardy</i> | | 15. SOCIAL SECURITY NO. <i>Unknown</i> | | INFORMANT Address <i>Dorothy I. Wilson-Wife - Item #2</i> | |
| 16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> | | | | | | | |
| DUE TO <i>420.0</i> | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Arteriosclerotic Heart Disease</i> | | | | | | | |
| DUE TO (c) <i>Generalized Arteriosclerosis</i> | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that I attended the deceased from <i>8/27, 1952</i> , to <i>11/28, 1959</i> , that I last saw the deceased alive on <i>11/25, 1959</i> , and that death occurred at <i>10:30 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>M.D. 8106 Maple Ridge Rd.</i> | | | | | | | |
| DATE SIGNED <i>W. T. Joyce on 12-2-59</i> | | | | | | | |
| ACTUAL SIGNATURE <i>W. T. Joyce</i> | | PHYSICIAN'S NAME (Type) <i>William T. Joyce</i> | | 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>12-2-59</i> | |
| 22c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington National Cem.</i> | | 22d. LOCATION (City, town, or county) (State) <i>Arlington, Virginia</i> | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey, Bethesda, Maryland</i> | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE <i>DEC 2 '59</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> | |



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12853

Reg. Dist. No.

12849

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>Md</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> | | c. LENGTH OF STAY IN 1b <i>3 yrs</i> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> | | d. COUNTY <i>Montgomery</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>10009 Reddick Rd.</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Nellie Esther Wiseman</i> | | First <i>Nellie</i> | Middle <i>Esther</i> |
| 4. DATE OF DEATH Year <i>Nov 16 1957</i> | | Month <i>Nov</i> | Day <i>16</i> |
| 5. SEX <i>Female</i> | | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <i>12-20-xx</i> |
| 8. DATE OF BIRTH <i>1884</i> | | 9. AGE (In years, months and days) last birthday <i>73 yrs.</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Neb.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>21-SG</i> | |
| 13. FATHER'S NAME <i>J. H. Hartman</i> | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>None</i> | |
| 17. INFORMANT <i>Thelma Lewis - daughter - Ida 2</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (b) (c) | | | |
| INTERVAL BETWEEN ONSET AND DEATH <i>Found dead in bed</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) <i>Frank J. Broschart</i> | | DATE <i>11-16-57</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>SHIP & BURIAL</i> | | 22b. DATE THEREOF <i>NOV. 16, 1959</i> | |
| 22c. NAME OF CEMETERY OR CREMATORIUM <i>RAVENNA CEMETERY(BUFFALO CO)</i> | | 22d. LOCATION (City, town, or county) <i>RAVENNA, NEBRASKA</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren E. Pumphrey, Inc., Silver Spring, Md.</i> | | ADDRESS <i>Raymond A. Isaacs</i> | |
| 24a. REC'D BY REGISTRAR <i>NOV 18 59</i> | | 24b. REGISTRAR'S SIGNATURE <i>Albert J. Kenna</i> | |
| DATE | | | |



TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

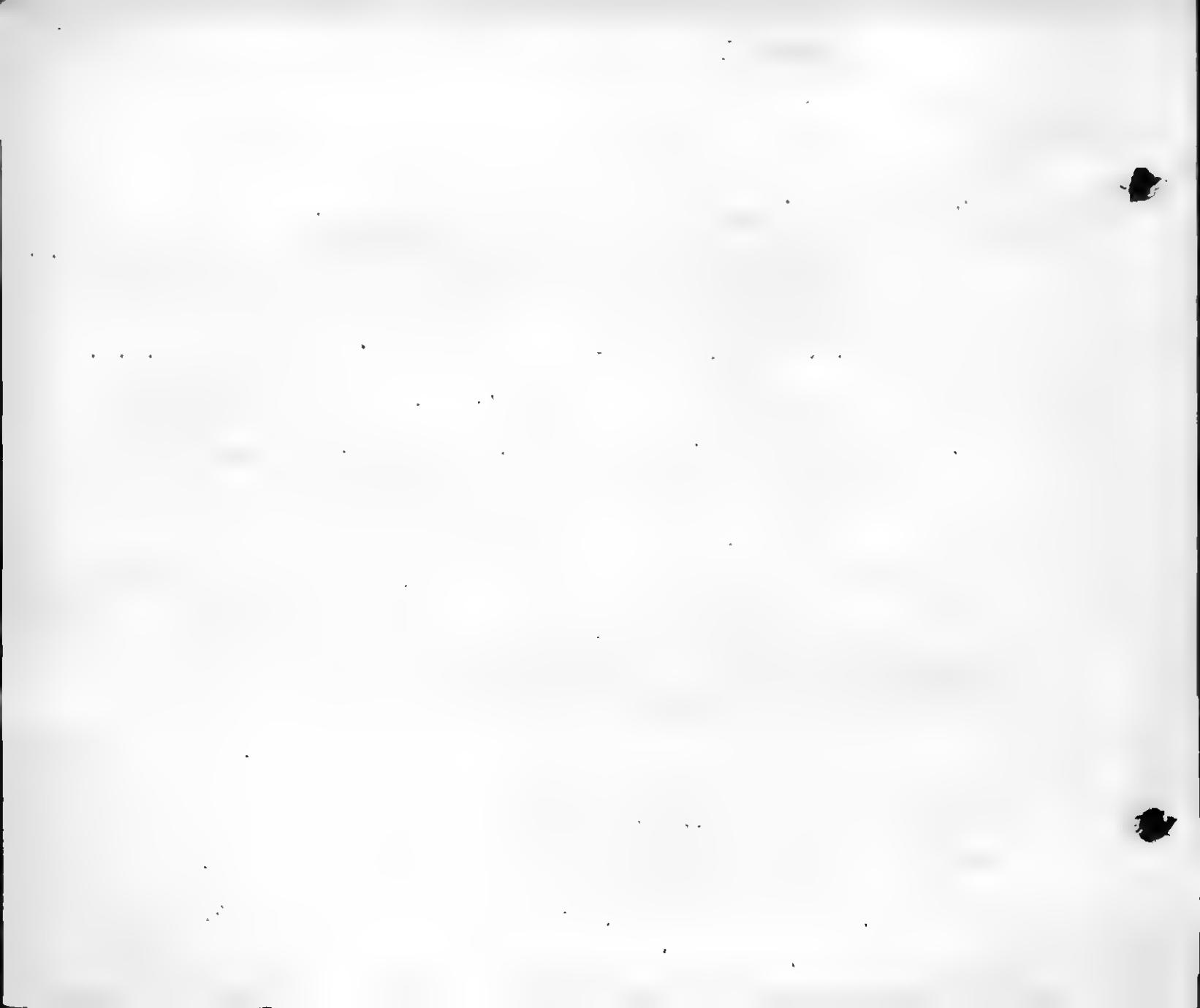
12850

CERTIFICATE OF DEATH

12854

Reg. Dist. No.

| | | | |
|--|-----------------------|---|------------------------------|
| 1. PLACE OF DEATH a. COUNTY Carroll Hall Sanitarium MARYLAND Montgomery | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Virginia b. COUNTY Arlington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington | | c. LENGTH OF STAY IN 1b RURAL | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Sanitarium | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington | |
| 3. NAME OF DECEASED (Type or print) WILLIAM | | d. STREET ADDRESS 3136 Key Blv'd. | |
| 4. DATE OF DEATH Last Month Day Year WITHEM 11 38 1959 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX Female | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-19-72 |
| 9. AGE (In years last birthday) 86 yrs. | | 10. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Pennsylvania | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME John Edward Witham | |
| 14. MOTHER'S MAIDEN NAME Anna T. Tomlinson | | 15. SOCIAL SECURITY NO. None | |
| 16. INFORMANT Mrs. Cassidy (executive appointee) | | 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) CHRONIC MYOCARDITIS DUE TO (c) GENERALIZED ARTERIOSCLEROSIS | |
| 18. INTERVAL BETWEEN ONSET AND DEATH | | 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) SENILITY | |
| 20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 10, 1957, to 11-07-81, 1959, that I last saw the deceased alive on 11-07-59, 1959, and that death occurred at 2:30 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Joseph Lawler, M.D. PHYSICIAN'S NAME (Type) | | ADDRESS (Street, city or town, state) 5206 Norway Dr., Cherry Chase Md. DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 12-2-1959 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill | | 22d. LOCATION (City, town, or county) (State) Suitland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph Lawler's Sons, Wash. 6, D.C. | | 24a. REC'D BY REGISTRAR DATE DEC 1 '59 | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

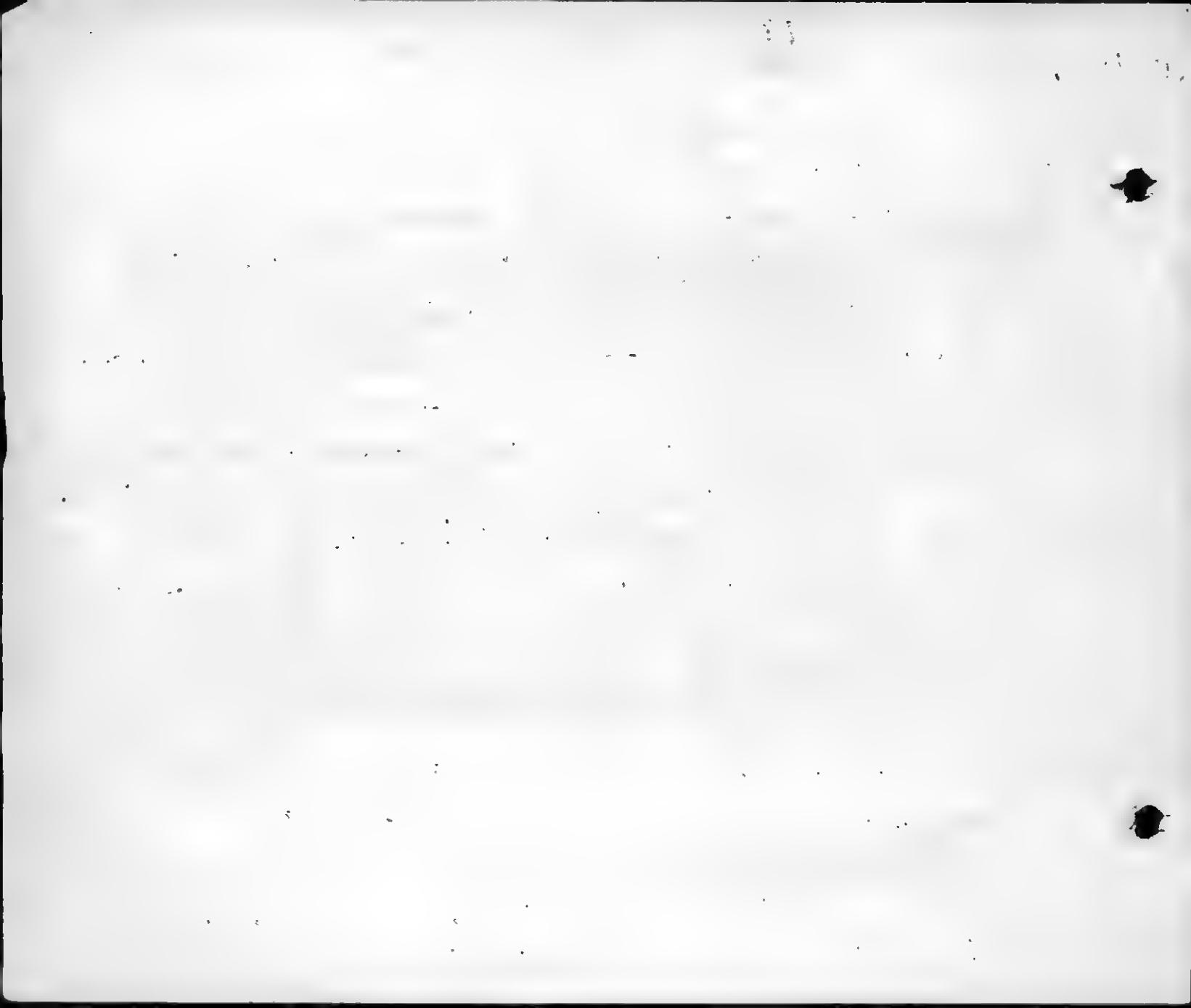
12851

CERTIFICATE OF DEATH

Reg. Dist. No.

12855

| | | | | | | | | | |
|--|--|---|---|---|--|--|----------------------|---------------------------------------|---------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 12 days, 14 hr. | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) d. STATE Maryland | | e. COUNTY Maryland | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First Sarah | Middle Hopert | Last Withers | 4. DATE OF DEATH NOV. 7, 1959 | | Month NOV. | Day 7 | Year 1959 |
| 5. SEX Female | | 6 COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH Nov. 7, 1917 | 9. AGE (in years last birthday) 12 yrs. | IF UNDER 1 YEAR Months 12 | | IF UNDER 24 HRS. Hours 0 | |
| 8. OCCUPATION none | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Marian Lee | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No | | 16. SOCIAL SECURITY NO. None | | INFORMANT Berry Withers, Crest Haven Drive, Md. | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days | | | |
| | | | | | | 1 month | | | |
| | | | | | | 1 year | | | |
| 20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 11-9 , 19 59 , to 11-12 , 19 59 . I first saw the deceased alive on 11-11 , 19 59 , and that death occurred at 5:30 AM , from the causes and on the date stated above. | | | | | | ADDRESS (Street, city or town, state) | | | |
| ACTUAL SIGNATURE Robert L. Snowden | | M.D. | | DATE SIGNED 11-12-59 | | | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/16/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Arlington National | | 22d. LOCATION (City, town, or county) (State) Arlington, Va. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden | | ADDRESS Bethesda, Md. | | 24a. REC'D BY REGISTRAR DATE NOV 18 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Trahan | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

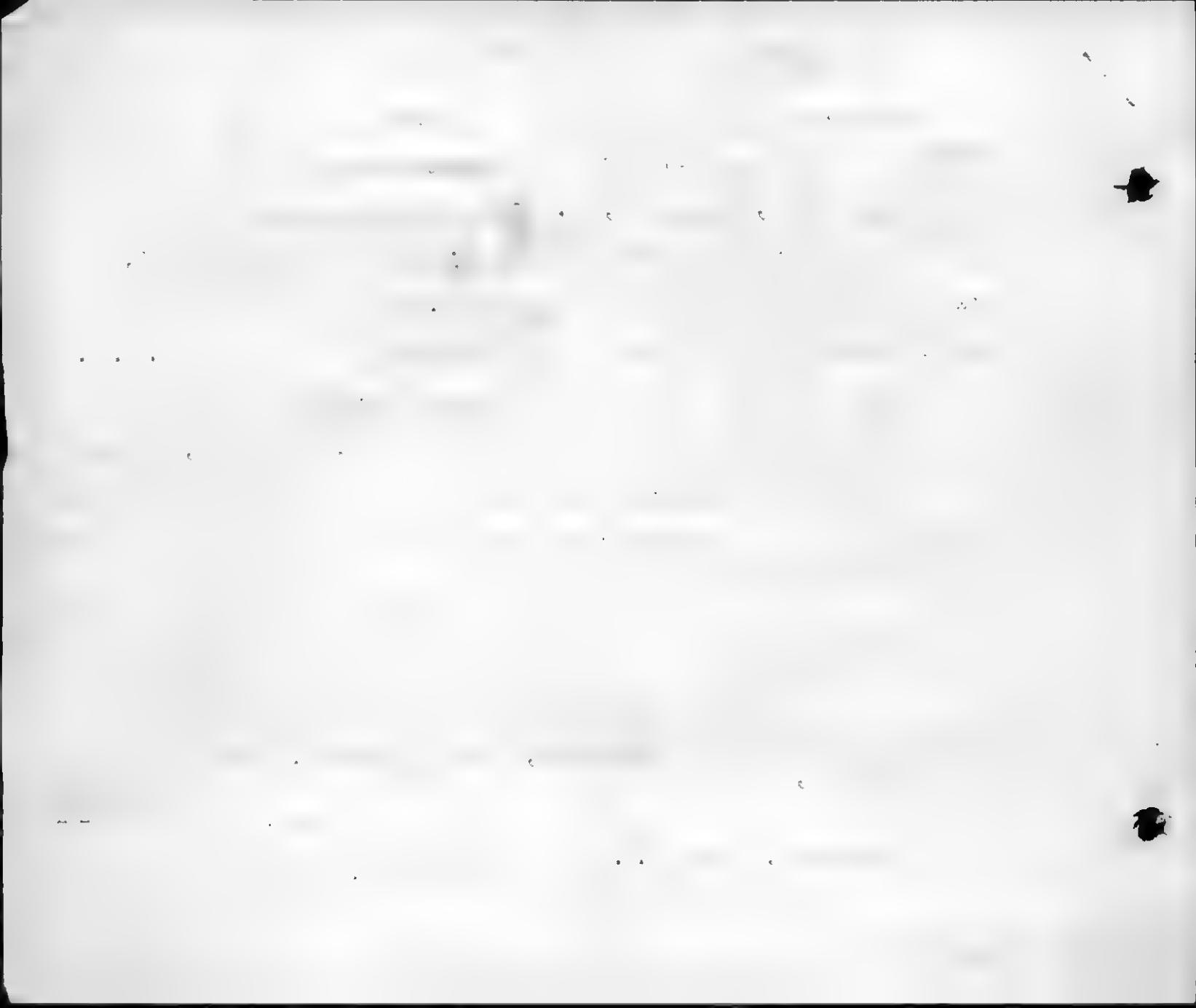
12852

CERTIFICATE OF DEATH

Reg. Dist. No.

12856

| | | | | | | | | | |
|---|----------------------------------|---|--|--|---|--|-------------------------------------|---|-------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN lb 17 days | 2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE Colorado | | b. COUNTY Colorado | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First Kurt | Middle Amandus | Last Wittges | 4. DATE OF DEATH November | Month 7 | Day 19 | Year 59 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH January 5, 1900 | 9. AGE (in years last birthday) 59 yrs | IF UNDER 1 YEAR Months 59 | IF UNDER 24 HRS Days 0 | Hours 0 | Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garage Manager | | 10b. KIND OF BUSINESS OR INDUSTRY Private | | 11. BIRTHPLACE (State or foreign country) Nebraska | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME Max Wittges | | 14. MOTHER'S MAIDEN NAME Hedwig Getzschmann | | INFORMANT The Medical Record | | Address The Clinical Center, Bethesda 14, Maryland | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. — | | 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 | | INTERVAL BETWEEN ONSET AND DEATH 24 hours | | | |
| | | | | DUE TO Cardiovascular collapse | | | | | |
| | | | | DUE TO Metastatic malignant carcinoid | | 5 years | | | |
| | | | | DUE TO Metastatic malignant carcinoid | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 21. I certify that I attended the deceased from October 21, 1959 , to November 7, 1959 that I last saw the deceased alive on November 7, 1959 , and that death occurred at 8:54 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Laurence S. Earley | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) El Paso Co. Colo. | | (County) El Paso Co. | (State) Colo. |
| 21. ACTUAL SIGNATURE Laurence S. Earley | | 22. PHYSICIAN'S NAME (Type) Laurence E. Earley, M.D. | | 23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 24. DATE THEREOF 11-12-1959 | | 25. FUNERAL DIRECTOR'S SIGNATURE Robert A. Murphy | |
| | | | | 26. NAME OF CEMETERY OR CREMATORIAL EVERGREEN Cem. | | 27. ADDRESS Bethesda, Md. | | 28. REC'D BY REGISTRAR NOV 12 '59 | |
| | | | | | | | | 29. REGISTRAR'S SIGNATURE Arthur S. Earley | |



1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12857

Reg. Dist. No.

1. PLACE OF DEATH

b. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN lb

1 Hr. + 25 min

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington Sanitarium + Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Md.

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

d. STREET ADDRESS

8401 Flower Ave

e. IS RESIDENCE ON A FARM?

YES NO

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

10. USUAL OCCUPATION (Give kind of work done & kind of business or industry during most of working life)

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

420.1

DUE TO

(b)

Acute Myocardial Infarction

2 hours

immediate

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(c)

Coronary Arteriosclerosis

several years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)

20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING

CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour

a. m.

p. m.

19

20d. INJURY OCCURRED

While

at work

Not while

at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and find that death resulted from: Natural causes Accident Suicide Homicide Undetermined cause

ACTUAL

SIGNATURE

EXAMINER'S

NAME (Type)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

Nov. 4, 1959

22c. NAME OF CEMETERY OR CREMATORIUM

George Washington Cemetery

22d. LOCATION (City, town, or suburb)

Prince Georges County, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

J. Arthur Walters

ADDRESS

254 Carroll St. NW

24a. REC'D BY REGISTRAR

DATE

NOV 3 '59

24b. REGISTRAR'S SIGNATURE

John E. K.

1. PLACE OF DEATH

b. COUNTY

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION

e. IS RESIDENCE

ON A FARM?

YES NO

f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

g. STREET ADDRESS

h. IS RESIDENCE

ON A FARM?

YES NO

i. DATE OF BIRTH

j. AGE (In years
last birthday)

k. IF UNDER 1 YEAR

Months

Days

Hours

Min.

l. IF UNDER 24 HRS.

Hours

Min.

Sec.

Micro.

DEPARTMENT OF DEFENSE - MILITARY INFORMATION POLICY

MILITARY INFORMATION POLICY

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | | | | | |
|--|--|-----------------------------|---|---|-------------------|---|--|--|--|--|------------------|--|--|--|
| Item 9 film G252 11-27-59 et 12695 CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| Reg. Dist. No. 12838 | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>1 year 2 mo.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u> d. STREET ADDRESS <u>517 University Blvd W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | First <u>Edna</u> | Middle <u>Nancy</u> | Last <u>Young</u> | 4. DATE OF DEATH | | | Month <u>11</u> | Day <u>20</u> | Year <u>1959</u> | | | |
| 5. SEX <u>f</u> | | 6. COLOR OR RACE <u>Wh.</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>3-1-08</u> | | 9. AGE (In years last birthday) <u>58 yrs.</u> | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>1</u> Hours <u>0</u> Min. <u>0</u> | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> | | | 11. BIRTHPLACE (State or foreign country) <u>PA.</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | |
| 13. FATHER'S NAME <u>Thomas Bowser</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Phoebe Shaffer</u> | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>none</u> | | | INFORMANT <u>PT's Hosp. Record</u> | | | Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain stem compression</u> DUE TO <u>193.0</u> INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Increased intracranial pressure</u> DUE TO (c) <u>Cerebral glioma approx 18 mos</u> | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) <u>Worthington</u> (County) <u>PA.</u> (State) <u>PA.</u> | | | | | |
| 21. I certify that I attended the deceased from <u>Aug 1958</u> to <u>Nov 1959</u> , 1959, that I last saw the deceased alive on <u>Nov 19, 1959</u> , and that death occurred at <u>4:40 P.M.</u> from the causes and on the date stated above. | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>John L. Lord</u> | | | | | | | | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>JOHN L. LORD</u> | | | ADDRESS (Street, city or town, state) <u>2025 Eye St NW Washington 25, D.C.</u> DATE SIGNED <u>11/20/59</u> | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL <u>11/22/59</u> | | | 22b. DATE THEREOF <u>11/22/59</u> | | | 22c. NAME OF CEMETERY OR CREMATORIUM <u>West Glade Run Presbyterian Church Cemetery</u> | | | 22d. LOCATION (City, town, or county) <u>WORTHINGTON, PA.</u> (State) <u>PA.</u> | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Zukas</u> | | | ADDRESS <u>Silver Spring, Md.</u> | | | 24a. REC'D BY REGISTRAR DATE <u>NOV 24 '59</u> | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kress</u> | | | | | |

